CERTIFICATE OF COVERAGE

PremierBlue

The Subscriber and the Dependents enrolled hereunder are entitled to Medical and Hospital Services in accordance with the terms and provisions of the Group Contract.

To the extent that benefits of this Certificate are part of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act (commonly known as ERISA), Premier Blue shall have full and exclusive authority to construe covered benefits that are stated in the Certificate.

Premier Blue
P.O. Box 3518
Topeka, Kansas 66601-3518

Premier Blue
A state qualified Health Maintenance
Organization offered by Premier Health, Inc.
(An Independent Licensee of the
Blue Cross And Blue Shield Association)

Premier Blue

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INTRODUCTION

Premier Blue is a Health Maintenance Organization set up and operated to offer a comprehensive prepaid program of health care in Kansas which will provide health care services for Members in order to protect and promote their health.

The Group (as defined below) has indicated its desire to participate in the comprehensive prepaid program of health care offered by Premier Blue.

In consideration of the above, and the payment of the required Dues and the services provided under the Contract, the parties to the Contract (the Group and Premier Blue) agree to the following:

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

SECTION A. DEFINITIONS

1. **"Accidental Injury"** means an injury to a Member's body that is caused solely through, external, violent, and accidental means. "Accidental Injury" does **not** include hernia: injuries to the natural teeth caused by an accident; disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound).
2. **"Allowable Charge"** means the amount that Premier Blue determines to be the maximum amount for service(s) provided.
3. **"Alternate Recipient"** means any child of a Member who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Benefit Description.
4. **"Ambulance Service"** means any form of transportation which is specially designed, constructed, equipped, and intended to be used for the purpose of transporting sick or injured humans and which is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.
5. **"Biologically Based Mental Illness"** means the following:
   - **a.** Schizophrenia, schizo affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
   - **b.** Major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
   - **c.** Obsessive compulsive disorder;
   - **d.** Panic disorder;
   - **e.** Pervasive developmental disorder, including autism;
   - **f.** Other childhood mental illnesses, including attention deficit disorder and attention deficit hyperactive disorder; or
   - **g.** Borderline personality disorder.
6. **"Case Management"** means a process conducted by Premier Blue which:
   - **a.** Identifies cases involving a Member which presents either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services.
   - **b.** Assesses such for the appropriateness of the level of patient care and the setting in which it is received;
   - **c.** Reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and
   - **d.** Evaluates and monitors the requested services for cost efficient use of benefits.

   The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Member would otherwise be entitled under the terms of this Certificate of Coverage.

   If Premier Blue elects to provide benefits for a Member in one case, it shall not obligate Premier Blue to provide the same or similar benefits for the same or another Member in the same or another case.

   Participation in Case Management is voluntary. The Member may withdraw at any time and return to the stated benefits of this Certificate of Coverage.
7. **"Coinsurance"** means the percentage of the Allowable Charge for a covered service at which payment is made after any applicable Copayment amount has been satisfied.
8. **"Contract"** means the written agreement entered into by the Group and Premier Blue, for the provision of Medical and Hospital Services.
9. **"Contracting Hospital"** means a Hospital which has a written agreement with Premier Blue to provide Hospital Services to Members.
10. **"Contracting Provider"** means a Physician, Contracting Hospital, Nursing Facility, Home Health Agency or any other licensed institution or Health Professional, that has a written agreement with Premier Blue to provide health services to Members.
11. **"Convalescent Care, Custodial/Maintenance Care or Rest Cures"** means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other care givers who are not Health Professionals. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.
12. **"Copayment" or "Copay"** means the amount to be paid by a Member before benefits can be provided for a covered service. A Copayment is required each time a specific service such as an office visit is provided. A Copayment does not accumulate toward a specified maximum**.**
13. **"Coverage"** means the services provided under the Contract in consideration of appropriate payment of Dues for such Coverage for a Subscriber and enrolled Dependents.
14. **"Cosmetic"** means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
15. **"Credible Evidence"** means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.
16. **"Dependent"** means members of the Subscriber's family who meet the eligibility requirements for Coverage hereunder and who have been enrolled in this program by the Subscriber, and for whom the required Dues have been received by Premier Blue.
17. **"Dues"** means the sum of money paid periodically to Premier Blue by the State of Kansas in order for the Member to receive the services and benefits covered by the Certificate of Coverage.
18. **"Enrollment Area"** means the area in which the Member must reside to be eligible for this program.
19. **"Experimental or Investigational"** refers to the status of drug, device or medical treatment or procedure:
    - **a.** If the drug, device or medical treatment or procedure cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not

been given at the time the drug or device is furnished and the drug, device or medical treatment or procedure is not Research-Urgent as defined in these General Definitions; or

b. If Credible Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions; or

c. If Credible Evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions; or

d. If there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis.

20. "Group" means the business organization or legal entity which has entered into the Contract with Premier Blue on its own behalf and for the Member, for the provision of medical and Hospital services. Group is a party to the Contract.

21. "Health Management Benefits" means a comprehensive package of benefits identified in this Certificate of Coverage for specified chronic diseases and intended to improve long-term patient outcomes.

22. "Health Professional" means a Physician, dentist, certified psychologist, optometrist, chiropractor, podiatrist, osteopath or other professional engaged in the delivery of health services who is licensed, certified or otherwise practices under the authority of appropriate state laws.

23. "High-Dose Chemotherapy" is defined as the dose of chemotherapy which exceeds standard doses of chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells must be implanted or infused to keep the patient alive. Thus, the role of autologous bone marrow transplantation or peripheral stem cell support is not as a treatment, but to restore the bone morrow destroyed by the High-Dose Chemotherapy.

24. "Home Health Agency" means a public agency or private organization which is primarily engaged in providing skilled nursing services and therapeutic services in the patient's place of residence; has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides; maintains clinical records on all patients; is licensed according to state and local laws; and is certified by Medicare.

25. "Hospice or Hospice Facility" means a legally constituted, Medicare certified, organization or agency, centrally administered, medically directed, nurse coordinated program providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families. It systematically joins together employed professionals and trained volunteers to form an interdisciplinary group, to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during the dying and bereavement processes.

26. "Hospice Care Plan or Hospice Care Program" means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan will be designed to provide care to meet the special needs during the final stages of a terminal illness.

27. "Hospice Care Services" means any services provided by (a) a Participating Hospital, (b) a participating Skilled Nursing Facility or similar institution, (c) a participating home health care agency, (d) a Hospice Facility or (e) any other licensed facility or agency under a Hospice Care Program, and is a Medicare approved Hospice Care Program.

28. "Hospice Patient" means a patient diagnosed or referred, or both, to a Hospice as terminally ill by an attending Physician, who alone, or in conjunction with designated family members, has voluntarily requested admission into a hospice program or whose guardian has requested admission on behalf of such patient into a hospice program and who has been accepted into a hospice program. Written certification by the patient's Doctor that the Hospice Patient has a life expectancy of 6 months or less is required.

29. "Hospice Patient's Family" means the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relation and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

30. "Hospice Team or Interdisciplinary Group" means the attending Physician, and the following hospice personnel: Physician, licensed professional or licensed practical nurse, licensed social worker, pastoral or other counselor. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

31. "Hospital" means a facility that: (a) provides, on a continuous Inpatient basis, diagnostic and therapeutic services for the surgical, medical and psychiatric diagnosis, treatment and care of injured or sick persons; and (b) provides such services by or under the supervision of a professional staff of licensed Physicians and surgeons; and (c) continuously provides 24-hour-a-day nursing services by registered nurses. To qualify as a Hospital, the facility must also be accredited by the Joint Commission on Accreditation of Hospitals or be certified as a Hospital by Medicare, and also meet all licensure and certification requirements of its applicable local or state regulatory agencies.

The term Hospital does not include rest homes, places that are primarily for the care of convalescents, nursing homes, Skilled Nursing Facilities, health resorts, clinics, doctors offices, private homes, ambulatory surgical centers, residential or transitional living centers, or similar facilities.

32. "Hospital Services" (except as expressly limited or excluded by this Certificate of Coverage) means those services which (a) are provided to registered Inpatients or Outpatients by an acute care general Hospital; and (b) are listed in the Schedule of Benefits.

33. **"Identification Card"** means a card issued to identify you as a Member of Premier Blue.

34. **"Inpatient"** means a setting in which services are provided to a person who has been admitted to a Hospital or Medical Care Facility.

35. **"Inpatient Facility Based Rehabilitation"** means rehabilitation services that are payable for inpatients residing in hospitals at an acute level of care, subject to the Medical Necessity provisions of the health plan. Only facilities with acute care license (hospitals) that provide short and long term rehabilitation services are considered appropriate.

36. **"Manipulations"** means the skillful or dextrous treatment or procedure involving the use of the hands. In physical therapy, the forceful passive movement of a joint beyond its active limit of motion.

37. **"Medical Care Facility"** means a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Nervous or Mental Condition.

38. **"Medical Director"** means a Physician charged with the direction and management of Contracting Premier Blue Physicians or his/her designee.

39. **"Medical Emergency"** means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

40. **"Medically Necessary/Medical Necessity"** means a service required to diagnose or to treat an illness or injury. To be Medically Necessary, the service must: be performed or prescribed by a Health Professional; be consistent with the diagnosis and treatment of the Member's condition; be in accordance with standards of good medical practice; not be for the convenience of the patient or his Doctor; and be performed in the most appropriate setting or manner appropriate to treat the Member's medical condition.

    Premier Blue will provide benefits only for Medically Necessary services. To determine if services are Medically Necessary, Premier Blue may require information related to (but not limited to) medical records, medical history, the service performed, the admission, and continued care.

41. **"Medical Services"** (except as expressly limited or excluded by this Certificate of Coverage) means those services of Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services which are included in the Schedule of Benefits and which are performed, prescribed or directed by the Member's designated Primary Care Physician at the time the service is provided.

42. **"Medicare"** means the Health Insurance for the Aged Act (Title XVIII of the Social Security Act Amendments of 1965, as amended now and in the future). The term Medicare includes any rules and regulations authorized by that Act and any law designed specifically to replace that Act.

43. **"Member"** means Subscribers and Dependents enrolled in Premier Blue.

44. **"Modalities"** means a method of application or the employment of any therapeutic agent, limited usually to physical agents.

45. **"Open Enrollment"** means the period of time during which eligible persons who have not previously enrolled with Premier Blue may do so. Open enrollment will occur at least once every twelve consecutive months and last for one month. The Open Enrollment period is established by the Group and Premier Blue.

46. **"Out-of-Area Emergency"** means an Accidental Injury or illness that requires immediate and unexpected care and that occurs while the Member is temporarily away from his/her regular residence and more than 30 miles from his/her Primary Care Physician's office. This does not include coverage for any maternity care related to normal term delivery but does include care for complications of pregnancy or unexpected delivery.

47. **"Outpatient"** means a setting in which services that are provided which is other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an ambulatory surgical center, a clinic or a Physician's office.

48. **"Outpatient Facility Based Rehabilitation"** means rehabilitation services provided for outpatient treatment provided in an acute hospital or clinic setting (including services from a registered Physical Therapist or Occupational Therapist in this setting. Clinic for the purposes of this provision shall mean: an institution connected with a hospital or medical school where diagnosis and treatment are made available to outpatients).

49. **"Outpatient Office Based Rehabilitation"** means all rehabilitation services provided in a health care provider's office.

50. **"Palliative Care"** means treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

51. **"Physician"** means a licensed doctor of medicine or osteopathy. Physician also means the following practitioners: podiatrist, optometrist, chiropractor, certified psychologist; or any other person who is licensed to provide professional services within the scope of that license or certification.

52. **"Plan"** means the specific Premier Blue Coverage selected by the Group and by Subscribers within the Group.

53. **"Premier Blue"** is a health maintenance organization which is organized under the laws of Kansas.

54. **"Primary Care Physician" or "PCP"** means the Physician selected by the Member from the list of Physicians engaged in general practice, family practice, internal medicine or pediatrics who is participating in the Premier Blue program to be the Physician who will manage the Member's health care needs.

55. **"Proof of Loss"** means documentary evidence required by Premier Blue to prove a valid claim exists. See Proof of Loss provision in the REIMBURSEMENT FOR SERVICES section for information concerning the time frames within which Proof of Loss must be submitted to Premier Blue.

56. **"Rehabilitation Services"** means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following

an Accidental Injury or an illness including physical therapy, speech therapy and occupational therapy.

57. "Research-Urgent" means a drug, device, medical treatment or procedure that is otherwise excluded by this Certificate of Coverage as Experimental or Investigational (see General Definitions and General Exclusions) but meets all the following criteria:

a. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.

(1) For purposes of Research Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.

(2) For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.

b. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.

c. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Member seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc or by an institution or entity for which the protocol for the drug, device, medical treatment or procedure has been approved by its Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by Federal Departments and Agencies that have adopted the Federal Policy for the Protection of Human Subjects.

d. The drug, device, medical treatment or procedure is not available free or at a reduced cost.

e. The drug, device, medical treatment or procedure is not excluded by another provision of this Certificate of Coverage.

Coverage is not available for drugs and biologicals that are available under the prescription drug program sponsored by the Group.

58. "Service Area" means the geographical area of the Premier Blue program.

59. "Skilled Nursing Facility" means a Medicare Certified institution (or distinct part of an institution) which provides covered extended care services to Members.

60. "Subscriber" means a person who meets all applicable eligibility requirements of Section B and who enrolls hereunder, and for whom the prepayment required by Section J shall have been received by Premier Blue.

61. "Terminal Illness" means an illness, of a Member, which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.

62. "Urgent Care Facility" means a health care facility that is physically and financially separate from a Hospital, the primary purpose of which is to provide immediate, short-term medical care for urgent medical conditions.

SECTION B. ELIGIBILITY

Who is Eligible

1. Subscriber To be eligible to enroll as a Subscriber, a person must:

a. Reside in the Enrollment Area of the Premier Blue program at least six (6) months per contract year as indicated under "Group's Enrollment/Eligibility Rules" and intend to be a patient of a Primary Care Physician of the program;

b. Be an employee of, or participant in, the Group;

c. Meet and continue to meet all eligibility requirements for participation in the health benefit program established by the Group; and

d. Not be ineligible by reason of any past disciplinary action initiated by the health plan.

2. Dependent. To be eligible to enroll as a Dependent, an individual who is not ineligible by reason of any past disciplinary action initiated by the health plan, must be listed as eligible for coverage in Premier Blue's records according to the specifications set forth in the Enrollment and Effective Dates Section and must be at the time of enrollment one of the following:

Spouse: The Subscriber's lawful spouse who resides in the Service Area at least six (6) months per contract year and is eligible under "Group's Enrollment/Eligibility Rules".

Children: A natural child, adopted child, step-child, a child supported by the Subscriber pursuant to a valid court order or a child for whom the Subscriber is the legal guardian, who resides in the Service Area at least six (6) months per contract year and is eligible under "Group's Enrollment/Eligibility Rules".

NOTE: If a Dependent is temporarily residing outside the Service Area, the only services that are covered are emergency services unless the Dependent has been referred for services by their Primary Care Physician.

SECTION C. CHOICE OF MEMBERSHIP TYPE AND PRIMARY CARE PHYSICIAN

1. The person named on the Identification Card may choose one of the following membership types, subject to the Group's election of enrollment categories:

a. Member Only Membership, to include Coverage for the person named on the Identification Card only.

b. Member/Spouse Membership, to include Coverage for the person named on the Identification Card and the spouse of the person named on the Identification Card.

c. Member/Child (Children) Membership, to include Coverage for the person named on the Identification Card and one or more children who meet eligible dependent requirements.

d. Member/Spouse/Children Membership, to include Coverage for the person named on the Identification Card and Dependents.

2. When making written application for membership, a Primary Care Physician must be designated for each eligible person to be enrolled. The applicant has the right to choose any Primary Care Physician subject to their practice restrictions.

The Primary Care Physician selected by a Member has the right not to accept the Member as a patient or to cease being the Primary Care Physician for a Member. In such case, Premier Blue will notify the Member of the need to select a new Primary Care Physician.

SECTION D. ENROLLMENT AND EFFECTIVE DATES

1. Initial Establishment of a Membership

The Group shall submit to Premier Blue an individual application for each eligible employee electing Coverage. These applications will be accepted if completed within 31 days and received by Premier Blue within 45 days of the person's date of initial eligibility to enroll.

If the Group offers a choice of two or more optional health benefit programs, a Subscriber may elect only one of the programs offered.

For those who are enrolling at their initial opportunity, Coverage will be effective on the first day of the month following the initial opportunity to enroll as long as the application is completed within 31 days and received by Premier Blue within 45 days of the person's initial opportunity to enroll.

For those who do not make application within the time periods set forth above, but who are enrolling in conjunction with an event, as defined by state or Federal law, that qualifies them for Coverage, such membership will be effective on the first day of the month following the event that qualifies them for Coverage as long as the application is received by the Group within 31 days of the event.

Late Enrollees (see definition below) will be denied but may enroll during the next Open Enrollment. The membership will be effective the first day of the next Benefit Period.

The eligibility rules of the Group will govern the effective date of Coverage.

2. Making Changes to Membership Types

The Group shall notify Premier Blue when a Subscriber's membership should be changed to either add or drop a Dependent or Dependents when such a change would result in the establishment of a different membership type, e.g., employee only membership to employee/spouse membership or vice versa. If the notice of change is received by the Group within 31 days of the Subscriber's marriage date or the date of the event, as defined by state or Federal law, which qualifies the Dependent for Coverage hereunder, such change will be accepted.

Changes in membership type will be effective on the first day of the month following the date the Dependent becomes eligible for Coverage (unless otherwise specified) as long as the request to change is received by the Group within 31 days of the event, as defined by state or Federal law, that qualifies the person(s) being added.

Late Enrollees (see definition below) will be denied but may submit a notice of change during the next Open Enrollment. The change in membership type will be effective the first day of the next Benefit Period.

All newly added Dependents must designate a Primary Care Physician.

3. Adding Eligible Dependents to an Existing Membership that Includes Dependent Children

The Subscriber named on the Identification Card shall notify the Group within 31 days of the event that qualifies the dependent to be eligible for coverage when a new Dependent is to be added to an existing membership type that includes coverage for the person(s) being added. If notification is not received by Premier Blue within 31 days of the event that qualifies the dependent to be eligible for coverage, that dependent will not be deemed a Member but will be considered a Late Enrollee. Such notification is not required for newborn dependents.

Premier Blue requires that each person covered be recorded on Premier Blue's records. Claims for Dependents not on record will be denied until it has been established that the Dependent is a Member.

When a new dependent is to be added to a membership, the Subscriber named on the Identification Card should notify the Group of the Dependent's name, date of birth, sex, and relationship.

For those Dependents to be added for which the Group receives notification within 31 days of the event that qualifies the dependent to be eligible for coverage, the new Dependents' coverage will be effective the date of the event that qualifies the Dependent for coverage (e.g. date of marriage, birth, adoption, etc.).

Late Enrollees (see definition below) will be denied but may submit a notice of change during the next Open Enrollment. The change in coverage will be effective the first day of the next Benefit Period.

The eligibility rules of the Group will govern the effective date of Coverage.

All newly added Dependents must designate a Primary Care Physician.

4. Newborn Child/Adopted Child Coverage

Notwithstanding any provision to the contrary, under an existing membership type that provides benefits for two or more Subscribers, a newborn of the person named on the Identification Card or the spouse of the person named on the Identification Card or a child (regardless of age) adopted by the Subscriber or placed in the Subscriber's home by a child placement agency as defined by state law for the purpose of adoption, is covered as follows:

a. In the case of natural newborns, newborns for which the petition for adoption has been filed within 31 days following birth or newborns placed in the Subscriber's home within 31 days following birth: Coverage will be effective and provided without charge for 31 days beginning on the date of birth.

b. In the case of adoptions subsequent to the first 31 days of birth: Coverage will be effective and provided without charge for 31 days beginning on the date the petition was filed.

c. In the case of placement of a child in the Subscriber's home by a child placement agency as defined by state law for the purpose of adoption subsequent to the first 31 days of birth; Coverage will be effective and provided without charge for 31 days beginning on the date of placement, as certified by the Subscriber.

Under a membership type that provides benefits for children, no change in membership type is required nor are additional membership Dues required to continue that child's Coverage beyond the first 31 days.

Under a membership that provides benefits for an employee and spouse only, the membership must be changed to a membership type that would include the child in order for the child to have Coverage beyond the first 31 days of Coverage. If notice of change is received by the Group within 31 days of the birth, the date the petition for adoption was filed or the date the child was placed in the Subscriber's home, the membership will be changed to include the child effective on the 32nd day following the child's date of birth, the date the petition for adoption is filed or the date of placement in the Subscriber's home (whichever is applicable). Membership Dues for the new membership type will be charged from that date.

In the case of a membership that provides benefits for only one Subscriber, if the notice of change is received by the Group within 31 days of the birth, the date the petition for adoption was filed or the date of placement, the membership will be changed to include the child effective on the child's date of birth, the date the petition for adoption is filed or the date of placement in the Subscriber's home (whichever is applicable). Membership Dues for the new membership type will be charged from that date.

If the notice of change is not received within the required 31 days, the notice of change may be submitted during the next Open Enrollment and the change will be effective the first day of next Benefit Period. Membership Dues for the new membership type will be charged from the date the change is effective.

5. **Dependent Coverage pursuant to a Qualified Medical Child Support Order:**

   Coverage will be effective on the first day of the month following the date on which the Group qualifies the Order. Medical Child Support Orders must be qualified by the Group pursuant to specifications of Federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the Group for initial qualification or rejection. The Group will forward the Order to Premier Blue for an Identification Card, Certificate of Coverage and claim form to be issued to the Alternate Recipient.

6. **Late Enrollee.** As used herein a "Late Enrollee" means an eligible employee or Dependent who requests enrollment in the Contract after the initial enrollment period provided for under this Contract when such employee or Dependent was first eligible. The term "Late Enrollee" does not include an employee or Dependent if (1) such person was covered under a State Children's Health Insurance Program (SCHIP), Medicaid, or another employer provided health benefit plan at the same time such person was first eligible to enroll under this Certificate of Coverage, (2) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment, (3) has lost coverage under another employer health benefit plan except as a result of fraud of non-payment of premiums, and (4) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan. "Late Enrollee" also does not include a spouse or minor child when a court has ordered coverage to be provided for such spouse or minor child under this Certificate of Coverage or when a request to enroll a spouse or child is received by Premier Blue within 31 days of marriage, birth, adoption, placement for adoption or an individual who experiences any other "Special Enrollment Opportunity" as defined in the Health Insurance Portability and Accessibility Act of 1996 (HIPAA) and amendments thereto.

7. **Removing Dependents.** Dependents may be removed from a membership by submitting the necessary information to the Group.

8. **Membership Type.** The membership type (as described in Section C, paragraph 1) will be changed if necessary due to the addition or removal of Dependents.

9. **Subject to all provisions of this Certificate of Coverage, Coverage shall become effective as follows:**

   Coverage of a Subscriber or Dependent shall become effective at 12:01 a.m. on the first day of compliance with the eligibility requirements of Group and Premier Blue.

   If a Subscriber or a Dependent is confined in a Hospital on the effective date of Coverage the previous carrier is required by Kansas law to cover the Hospital confinement for a period of not less than 31 days following the expiration date of the prior carrier unless such coverage was replaced by other group coverage with no lapse in which case the prior carrier will provide benefits on a secondary basis. Premier Blue will cover the Hospital confinement beginning on the Member's effective date of Coverage. The Subscriber or Dependent must notify Premier Blue of the Hospital confinement within forty-eight (48) hours of the effective date or as soon thereafter as reasonably possible. Premier Blue reserves the right to assume direct management of the health care of such Member beginning upon assumption of coverage of the confinement and to transfer such Member to the care of a Participating Provider when the Premier Blue Medical Director determines it medically prudent to do so. In the event a Member fails to notify Premier Blue within the specified forty-eight (48) hour period (or as soon thereafter as reasonably possible) or refuses to permit Premier Blue to assume health care management or to be transferred to a Participating Hospital, Premier Blue is not responsible for or obligated to pay expenses relating to the Medical and Hospital Services rendered during this period of hospitalization.

SECTION E. PRIMARY CARE PHYSICIAN CHANGES

Primary Care Physician Changes. A Member may change his/her Primary Care Physician by telephoning Premier Blue. The change to a Member's Primary Care Physician will be made effective the first day of the month following receipt of notification by Premier Blue. If a Member's Primary Care Physician withdraws from the program, or in the event of the death of the Primary Care Physician, Premier Blue will notify the Member and require that the Member select a new Primary Care Physician from the list of those participating in the program. If the Member does not choose a new Primary Care Physician within 31 days of notification, Premier Blue will assign the Member a Primary Care Physician.

The Primary Care Physician selected by a Member has the right not to accept the Member as a patient or to cease being the Primary Care Physician for a Member. In such case, Premier Blue will notify the Member of the need to select a new Primary Care Physician.

SECTION F. TERMINATION OF COVERAGE

1. **Termination of the Group's Contract**. The Group's Contract shall continue in effect subject to the following:
   - **a.** The Group or its designated agent shall remit to Premier Blue on behalf of each Subscriber and his/her Dependents the amounts required for Coverage. Such remittance is due in the office of Premier Blue in advance of the effective date of Coverage and on the first day of each subsequent remittance period, unless otherwise agreed upon by the Group and Premier Blue.
   - **b.** If Coverage under the Contract is terminated because of nonpayment of the monthly Dues by the Group, Premier Blue has the right to decide whether or not to reinstate the Contract. If Coverage is reinstated, the Group is liable for the monthly Dues for its Members for the reinstated period, and Coverage for Members will be continuous.
   - **c.** The Group's Contract may also be terminated by Premier Blue for the following reasons. In such event, Coverage hereunder shall terminate for all Members as of the date of termination of the Coverage.
     - **(1)** Fraud or misrepresentation of a material fact by the Group.
     - **(2)** Non-Compliance with provisions of this Contract
     - **(3)** Failure to meet or maintain the participation or employer contribution requirements of Premier Blue as set forth in the Premier Blue enrollment regulations.
     - **(4)** Premier Blue ceases to offer a particular type of group coverage provided the provisions of Kansas law associated with such action are met. In such event, Premier Blue must notify the Group by June 1 and continue coverage for the Group for the remainder of the Benefit Period.
     - **(5)** When there is no longer any eligible employee, Member or Dependent enrolled under this Certificate of Coverage who lives or resides in the Enrollment Area.

     Termination for the foregoing reasons will be effective on the date specified by Premier Blue in a written notice of termination.
   - **d.** The Group's Contract may be terminated by the Group by giving 30 days prior written notice to Premier Blue. In such event, Coverage hereunder shall terminate for all Members as of the date of termination of the Contract.

2. **Termination of a Member's Coverage.** Coverage for a Member will terminate as follows:
   - **a.** If a Member ceases to meet the eligibility requirements of Section B, Coverage shall terminate effective the first day of the month following the date on which eligibility ceases.
   - **b.** If the Group's Contract is terminated, Coverage automatically ceases for all the Group's Members as set out in paragraph 1 above, except for a Member who is receiving Inpatient Hospital services when that person's Coverage terminates. In such case, benefits may be extended for that Member without payment of additional Dues for a period not less than 31 days following the termination of the Coverage. This extension of benefits will be terminated upon the earlier of:
     - **(1)** The completion of a 31 day period following termination of Coverage; or
     - **(2)** The date Hospital confinement ends; or
     - **(3)** The date replacement coverage takes effect in which case the terminating coverage will become secondary to the replacement coverage.
   - **c.** If the monthly payment for a Subscriber or Subscriber and Dependent(s) is not received with the Group's monthly payments, Coverage for that Subscriber and his/her Dependent(s), if any, shall terminate effective the day following the end of the period for which monthly payment has been made.
   - **d.** If the Subscriber becomes covered under any other health benefits plan offered by, through or in connection with the Group as an option in lieu of Coverage under this Certificate of Coverage, then Coverage shall terminate for the Subscriber and his/her Dependent(s) on the effective date of such other coverage.
   - **e.** If the Member permits the use of his/her or any other Member's Premier Blue Identification Card by any other person, or uses another person's card, all rights of the Member and Dependents who are members of his/her family unit may be terminated effective immediately upon written notice.
   - **f.** If the Member is guilty of fraud or repeated or gross misbehavior, including but not limited to abusive behavior toward providers and Premier Blue personnel in applying for or seeking any benefits under this Certificate of Coverage, then the rights of such Member under this Certificate of Coverage may be terminated. At the effective date of such termination, prepayments received on account of such terminated Member(s) applicable to periods after the effective date of termination shall be refunded and Premier Blue shall have no further liability or responsibility under this Certificate of Coverage.
   - **g.** When a Member is determined to be ineligible for coverage provided by the Group. All rights of the Member may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Member became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Member applicable to periods after the effective date of termination shall be refunded and Premier Blue shall have no further liability or responsibility under this Certificate of Coverage.

3. **Health Status.** No Member's Coverage shall be terminated by Premier Blue due to his/her health status or his/her health care needs. No eligible person shall be refused enrollment or re-enrollment because of his/her health status or healthcare needs.

4. **Certificate of Creditable Coverage.** You have the right to request and obtain a Certificate of Creditable Coverage from Premier Blue while you are a Member and up to 24 months following the date on which your coverage cancelled. To request a Certificate of Creditable Coverage contact the customer service center phone number on your Identification Card.

5. **Continuation of Coverage Under Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. - Federal Law** There is a Federal law which permits persons to continue coverage under an

employer group health plan. This law is referred to as COBRA which stands for "The Consolidated Omnibus Budget Reconciliation Act of 1986" and any amendments thereto. That law applies to employers of 20 or more employees and such employer's group health plans, not to insurance contractors. That is, if your employer changes from Premier Blue to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under Federal law is a right which transfers to the new carrier or to claims adjudication under the new administrator.

This section shall apply to the Group and its Members only if the Group is subject to the requirements of Title X of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any amendments thereto.

For more detailed information concerning COBRA, the Subscriber or Member should contact the Group.

Conversion Privilege Under COBRA

COBRA Members who complete the COBRA Continuance of Benefits period are then eligible for a conversion contract at the conversion contract rates then in effect. This conversion is only applicable to Members whose group offers Coverage with Premier Blue at the time the Member's eligibility under COBRA ends. Section G describes the conversion privilege in more detail.

Premier Blue shall not be obligated to provide COBRA coverage to you if the Group or Plan Administrator fails to timely notify you of your rights under COBRA or you fail to timely elect COBRA coverage.

6. USERRA Continuation Coverage - Federal Law

a. If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

b. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing conditions exclusions) except for service connected illnesses or injuries.

For more detailed information concerning COBRA, the Subscriber or Member should contact the Group.

SECTION G. CONTINUATION AND CONVERSION PRIVILEGE - STATE

1. The following provisions of Kansas laws governing group health insurance benefits for hospital, surgical and medical services apply to persons who do not have a right to continue coverage under the Federal law COBRA as that law is discussed in Section F. 5.

a. A Member whose Coverage under the Contract has been terminated for any reason including discontinuance of the Contract in its entirety or with respect to an insured class of persons, is entitled to have such coverage continued under the Contract, subject to the following provisions:

(1) The Member must have been continuously insured under the Contract (or a group policy providing similar benefits which was replaced by the Contract) for at least three (3) months immediately prior to termination.

(2) Such continued group benefits will be continued under the Contract for a period of six (6) months.

Clarifications:

(a) Where persons are on continued group benefits and during that 6-month period the Contract is replaced, such persons can finish out the 6-month period.

(b) A Dependent whose eligibility as a Dependent ceases during the 6-month period may complete the 6-month period on a separate, sponsored membership.

(3) Continued group benefits do not apply:

(a) When termination of Coverage under the Contract occurs because any Member failed to pay any required contribution.

(b) When the discontinued group Coverage is replaced by similar group coverage within 31 days.

(c) When the Member is or could be covered by Medicare.

(d) When the Member is or could be covered by any other insured or noninsured arrangement which provides prepaid or expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination.

(e) When a Member has had their coverage terminated pursuant to items 2.e., f. or g, of the Termination of Coverage (Section F).

(4) Notice of Right to Continue Group Benefits: The Subscriber must provide written notification to Premier Blue within 60 days of the date an event occurs which would qualify a Member for continued coverage under this provision. Premier Blue then has 14 days from the date the notice is received from the Subscriber, within which to provide the Subscriber with information explaining continuance rights. Finally the Subscriber has 60 days from receipt of that information to notify Premier Blue if continuance is desired. The Member whose Coverage is being terminated may continue group benefits by paying the required dues to Premier Blue.

The first required dues payment will be for a period commencing with the day following the date Coverage would otherwise terminate. No gap in Coverage will be permitted.

(a) Notice to the Subscriber: The notice will be mailed to the Subscriber's latest address as it appears on the records of Premier Blue.

(b) Notice to Dependents who cease to be eligible: The notice will be mailed to the Dependent at the address provided Premier Blue.

For those individuals who would otherwise be eligible for continued group benefits as specified above but who no longer reside in an Enrollment Area of Premier Blue may convert their membership to a conversion contract available through Blue Cross and Blue Shield of Kansas, Inc. by submitting a completed conversion application to Premier Blue and required payments within 31 days after termination of the group Coverage or receipt of notice of conversion rights from Premier Blue, whichever is later.

2. Conversion Privilege

a. A conversion privilege is available to the following persons:

(1) Those who have completed the period of continued group benefits provided for above.

(2) Those who during the period of continued group benefits provided for above choose to change to the Conversion Contract and so notify Premier Blue. (So doing forever forfeits any right to further continued group benefits mentioned above.)

(3) Those who at the time of initial eligibility for continued group benefits mentioned above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to continued group benefits mentioned above.)

No conversion privilege is available to a Member whose Coverage under this agreement is terminating as a result of the discontinued Premier Blue Group Coverage being replaced by similar group coverage within thirty-one (31) days, or the Member is or could be covered by any other insured or non-insured arrangement which provides prepaid or expense incurred hospital, surgical, or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination or to those who have had their coverage terminated pursuant to items 2.e., f. or g, of the Termination of Coverage (Section F).

b. When a Member is eligible for conversion as set forth above, the Member may convert his/her membership as follows:

The Member may convert his/her membership to a conversion contract available through Blue Cross and Blue Shield of Kansas, Inc. by submitting a completed conversion application to Blue Cross and Blue Shield of Kansas, Inc. and required payments within 31 days after termination of the group Coverage or receipt of notice of conversion rights from Premier Blue, whichever is later.

c. Conversion Notice

Persons who are enrolled in continued group benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

(1) Notice to the Subscriber: The notice will be mailed to the Subscriber's latest address as it appears on the records of Premier Blue.

(2) Notice to Dependents who cease to be eligible: The notice will be mailed to the Dependent at the address provided Premier Blue when Premier Blue is notified that such person is no longer an eligible Dependent.

d. The conversion contract does not require evidence of insurability of the person to be covered.

e. Application for conversion must be received by Blue Cross and Blue Shield of Kansas, Inc. within 31 days after termination of the group Coverage or receipt of notice of conversion rights from Premier Blue, whichever is later. The first required dues payment will be for a period commencing with the day following the date Coverage would otherwise terminate. No gap in Coverage will be permitted.

f. Failure to apply within the said 31 day period and to pay required payments to Blue Cross and Blue Shield of Kansas, Inc. will void the conversion privilege.

g. Conversion membership will be issued without evidence of insurability, but subject to all terms and conditions of Blue Cross and Blue Shield of Kansas, Inc. in effect prior to the time of application for conversion.

SECTION H. RELATIONSHIP OF PARTIES

1. **Independent Contractors.** The relationship between Premier Blue and Contracting Providers is an independent contractor relationship. Contracting Providers are not employees or agents of Premier Blue and neither Premier Blue nor any employee of Premier Blue is an employee or agent of Contracting Providers. Neither the Group nor any Member is the agent or representative of Premier Blue, and neither shall be liable for any acts or omissions of Premier Blue, its agents or employees, or a Contracting Provider, or any other person or organization with which Premier Blue has made or hereafter shall make arrangements for the performance of services under this Certificate of Coverage.
2. **Physician-Patient Relationship.** Physicians participating in this program maintain the Physician-patient relationship with Members and are solely responsible to Members for all Medical Services.
3. **Refusal of Treatment.** Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by their Primary Care Physician. A Physician may regard such refusal to accept his/her professional recommendations as incompatible with preservation and continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. If the Member refuses to accept such a recommended treatment or procedure, and the Primary Care Physician believes that no professionally acceptable alternative exists, such Member shall be so advised. If the Member still refuses to accept the recommended treatment or procedure, then neither the Primary Care Physician, other contracting Physician, nor the Plan shall have further responsibility to provide for the condition under treatment. The Member's remedy through Premier Blue will be the ability to change Primary Care Physicians (Section E) or the formal Grievance Procedure (Section L).
4. **Primary Care Physician/Patient Dismissal.** It is recognized that instances may occur where the PCP may, for good cause, find it impossible to establish an appropriate and viable Physician/patient relationship with a Member. Such Physician will notify the Member and Premier Blue in writing to require the Member to select another Primary Care Physician. The Member shall be notified in writing by Premier Blue and shall be given thirty (30) days to select another Primary Care Physician.
5. **Continuation of Care:** In the event a Contracting Provider is terminated from the program for any reason, and a Member is receiving covered Medically Necessary treatment in accordance with the dictates of medical prudence from such provider and the Member has special circumstances such as a disability, a life-threatening illness or is in the third trimester of pregnancy, the Member will have the right to request continuation of such covered treatment with that Contracting Provider for a limited time. If authorized, such continued treatment may extend for a period up to 90 days, or the date the special

circumstances invoking this provision no longer exist, whichever occurs earlier. In order to qualify for continued care with the Contracting Provider who is being terminated, the Member must make written request to Premier Blue. Premier Blue will review the matter and notify the Member as to whether or not such continued care is authorized. If continuation of care is authorized, the Member will continue to be responsible for the normal Copayment or Coinsurance amounts otherwise called for under the provisions of this Coverage.

SECTION I. COORDINATION OF THIS CERTIFICATE OF COVERAGE'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below determine which Plan will pay as the Primary Plan. The Primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

1. Definitions

a. A **"Plan"** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate Contracts are used to provide coordinated coverage for Members of a group, the separate Contracts are considered parts of the same Plan and there is no COB among those separate Contracts.

(1) "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; and governmental benefits, as permitted by law.

(2) "Plan" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; group or group-type accident only coverage, benefits for non-medical components of group long-term care policies; Medicare; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under a. or b. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

b. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Member.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

c. **"Allowable Expense"** means a health care service or expense, including Deductibles, Coinsurance and Copayment amounts, that is covered at least in part by any of the Plans covering the Member. When a Plan provides benefits in the form of services the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

(1) If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the Member's stay in a private hospital room is Medically Necessary, or one of the Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.

(2) If a Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

(3) If a Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, or if one Plan calculates its benefits or services on the basis of usual and customary fees and another Plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an Allowable Expense.

(4) The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

d. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a Member has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

e. **"Closed Panel Plan"** is a Plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

f. **"Custodial Parent"** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

2. Order Of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

a. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

b. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan

provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

c. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

d. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim

determination periods or plan years commencing after the Plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the custodial parent;
- The Plan of the spouse of the custodial parent;
- The Plan of the noncustodial parent; and then
- The Plan of the spouse of the noncustodial parent.

(3) Active or inactive employee. The Plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined in item 2.d.(1). above.

(4) Continuation coverage. If a person whose coverage is provided under a right of continuation provided by Federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

3. Effect On The Benefits Of This Plan

a. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a benefit reserve, the Secondary Plan will use the covered person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

b. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan,

COB shall not apply between that Plan and other closed panel plans.

4. Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Premier Blue may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Premier Blue need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Premier Blue any facts it needs to apply those rules and determine benefits payable.

5. Facility Of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, Premier Blue may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Premier Blue will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. Right Of Recovery

If the amount of the payments made by Premier Blue is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION J. PAYMENT OF DUES FOR COVERAGE HEREUNDER

Only Members for whom the stipulated Dues are actually received by Premier Blue shall be entitled to health services covered hereunder and then only for the period for which such Dues are received. If any required Dues are not received by the time specified above, and payment is not made within the grace period, all rights of such Member hereunder shall terminate at the end of the period for which monthly Dues have been paid and may be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Contract.

SECTION K. CERTIFICATE OF COVERAGES, IDENTIFICATION CARDS, CHANGES IN THE CONTRACT AND CERTIFICATES OF COVERAGES

1. Premier Blue will issue the Identification Cards and Certificates of Coverage for Subscribers of the Group. Identification Cards issued by Premier Blue pursuant to this Coverage are for identification only and possession of an Premier Blue Identification Card confers no right to services or benefits under the Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable Dues under the Contract have actually been paid. If any Member permits the use of his/her Premier Blue Identification Card by any other person, all rights of such Member and other covered Members of his/her family shall be immediately terminable at the will of Premier Blue.

2. The provisions of the Contract and/or Certificate of Coverage may be changed by Premier Blue by giving 30 days prior written notice to the Group, but only if such change is required as a result of change in state or federal legislation or unless otherwise agreed upon by the Group and Premier Blue, and evidenced by issuance of either a new rider, amendment, endorsement (or other proper written means) to this Contract. If the change also affects the Certificate of Coverage, the Group will be issued new Certificates of Coverage or written evidence of a change thereto.

SECTION L. CLAIMS PROCEDURES AND GRIEVANCE PROCEDURES

1. Purpose. Premier Blue recognizes that from time to time Members may encounter situations where the performance of Premier Blue does not meet their expectations. When this occurs, the Member may wish to call the matter to the attention of the Premier Blue management. It is the policy of Premier Blue to promptly and fairly consider all Grievances of its Members. The procedure outlined in this Section is established to define and assure this policy. In addition, this section outlines the procedures for and the time periods applicable to Claim decisions and Appeal decisions for Urgent Care Claims, Pre-Service Claims and Post-Service Claims. It is the policy of Premier Blue to afford Members a full and fair review of Claim decisions and Appeal decisions.

2. Claims Procedures

a. Definitions. For the purpose of this Claims Procedures Section, the following terms and their definitions apply:

(1) Adverse Decision, for the purposes of contractual Appeal procedures, means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which you are financially responsible or, for a Pre-Service Claim, for which you would be financially responsible, if you obtained the service. Adverse Decision, for the purposes of External Review procedures, is limited to the Claims identified in the definition of Adverse Decision Eligible for External Review.

(2) Adverse Decision Eligible for External Review means (1) in the case of other than a Medical Emergency, a Claim for a proposed or delivered health care service which would otherwise be covered under this Contract but for which the Member has received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by Premier Blue to be Experimental or Investigational and the denial leaves the Member with a financial obligation or prevents the Member from receiving the requested service, or (2) in the case of a Medical Emergency, a claim for which an initial Adverse Decision by Premier Blue that a proposed health care service which would otherwise be covered under this Contract is not Medically Necessary or the health care treatment has been determined by Premier Blue to be Experimental or Investigational and the denial would leave the Member with a financial obligation or prevents the Member from receiving the requested service. Not withstanding any provision of this Contract to the contrary, the External Review procedure is

not available for dental services, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by Premier Blue due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which you choose not to obtain the requested services. For item (3) above no Appeals need be submitted to Premier Blue in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the information in items d. and e. below applies.

(3) Appeal means a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to Premier Blue by the Member or the Member's Authorized Representative.

(4) Authorized Representative means, for non-urgent care, a person you designate in writing filed with Premier Blue as authorized to pursue an Appeal on your behalf. For Urgent Care, such written authorization is not required if the Appeal is made on your behalf by a health care provider with knowledge of your medical condition.

(5) Claim for Benefits or Claim means a request for treatment benefit or payment benefits made by the Member in accordance with Premier Blue's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Contract.

(6) External Review means the review of a final Adverse Decision by an External Review Organization.

(7) External Review Organization means an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.

(8) Pre-Service Claim means a request for a Claims decision when prior authorization of the services is required by Premier Blue.

(9) Pre-Service Request means a request for advance information on Premier Blue's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.

(10) Post-Service Claim means a request for a Claims decision for services that have been provided.

(11) Urgent Care means care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or, in the opinion of a Physician knowledgeable of the Member's condition, would subject the Member to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, Premier Blue must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Member's medical condition determines that a Claim involves Urgent Care, the Claim must be treated as an Urgent Care Claim.

b. Initial Claim Decisions

The time periods in which Premier Blue must make initial Claim decisions (the first determination of benefits available for a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Initial Benefit Decision (from the date the Claim is received by Premier Blue)	72 hours	15 days	30 days
Extension (from the date the Claim is received by Premier Blue)	None -Notice requesting additional information due – 24 hours*	30 days*	45 days*
* A Member may voluntarily agree to provide Premier Blue additional time within which to make a decision.			
Time for Member to provide more information (from the date the information was requested by Premier Blue)	48 hours	45 days	45 days

c. Appeal of Initial Adverse Decisions (first level Appeal)

A Member or the Member's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

(1) The time periods that apply to first level Appeal decisions are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to file Appeal (from the date Premier Blue made the initial Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by Premier Blue)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by Premier Blue)	None*	None*	None*
* A Member may voluntarily agree to provide Premier Blue additional time within which to make a decision.			

(2) A first level Appeal will be coordinated by a representative of Premier Blue's Customer Service Center. If the Member wishes an additional review of the Claim, a second level Appeal can be requested.

d. **Second level Appeal relating to an Adverse Decision that is not an Adverse Decision Eligible for External Review**

A Member or the Member's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from a first level Appeal. This is a second level Appeal.

(1) The time periods that apply to second level Appeal decisions are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to file Appeal (from the date Premier Blue made the first level Appeal Adverse Decision)	90 days	90 days	90 days
Initial Appeal Decision (from the date the second level Appeal is received by Premier Blue)	72 hours	15 days	30 days
Extension (from the date the second level Appeal is received by Premier Blue)	None*	None*	None*
* A Member may voluntarily agree to provide Premier Blue additional time within which to make a decision.			

(2) A second level Appeal will be coordinated by a representative of Premier Blue's Customer Service Center and the determination made by a person not subordinate to the first review.

e. **Second level Appeal relating to an Adverse Decision that is an Adverse Decision Eligible for External Review.**

(1) Waiver of second level Appeal. If a Member wishes to waive their right to a second level Appeal and proceed to the External Review, they may do so by sending written notice to Premier Blue. This waiver will serve to exhaust all of the available internal appeals or review procedures for the Claim being reviewed.

(2) Second level Appeal. If a Member chooses not to waive their right to a second level Appeal, the Member will have the right to appear in person before a designated representative or representatives of Premier Blue. At least one of those designated representatives who will be deciding the second level Appeal shall be a physician and shall be present in person, by telephone or by other electronic means. The Member has a right to:

(a) Receive from Premier Blue upon, request, copies of all documents, records and other information that are not confidential or privileged relevant to the Insured's request for benefits;

(b) have a reasonable and adequate amount of time to present the Member's case to a

designated representative or representatives of Premier Blue who will be deciding the second level Appeal;

(c) submit written comments, documents, records and other material relating to the request for benefits for the second level Appeal for Premier Blue to consider when conducting the second level Appeal both before and, if applicable, at the second level Appeal meeting;

(d) prior to or during the second level Appeal ask questions relevant to the subject matter of any representative of Premier Blue that is participating in the second level Appeal provided that such representative may respond verbally if the question is asked in person during a Member's appearance in conjunction with the second level Appeal or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

(e) be assisted or represented at the second level Appeal meeting by an individual or individuals of the Member's choice; and

(f) record the proceedings of the second level Appeal meeting at the expense of the Member.

(3) A Member, or the Member's Authorized Representative, wishing to request to appear in person in conjunction with the second level Appeal shall make the request to Premier Blue within five working days before the date of the scheduled second level Appeal meeting except that in the case of an emergency medical condition, such request must be made no less than 24 hours prior to the scheduled second level Appeal meeting.

(4) **Premier Blue** shall provide the Member a written decision setting forth the relevant facts and conclusions supporting its decision within:

(a) Seventy-two hours if the second level Appeal involves an Urgent Care Claim

(b) fifteen business days if the second level Appeal involves a Pre-Service Claim, and

(c) thirty days if the second level Appeal involves a Post-Service Claim.

f. Procedure for Pursuing an External Review

(1) The Member has the right to request an External Review of an Adverse Decision Eligible for External Review after a second level Appeal (where applicable) has been completed or when the Member has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Member. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving a Medical Emergency, such request may be made before the Member has exhausted all the other available review procedures. Premier Blue will notify the Member in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

(2) Within 90 days of receipt of the notice of a final Adverse Decision, the Member, the treating Physician or health care provider acting on behalf of the Member with written authorization from the Member, or a legally authorized designee of the Member must make a written request for an External Review to the Kansas Insurance Commissioner.

(3) Within 10 business days of receipt of such request (immediately, when the request for External Review involves a Medical Emergency), the Kansas Insurance Commissioner will notify the Member and other involved parties as to whether the request for External Review is granted.

(4) For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves a Medical Emergency. The standard of review shall be whether the health care service denied by Premier Blue was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by Premier Blue was covered or excluded from coverage under the terms of this Certificate of Coverage.

The right to External Review shall not be construed to change the terms of coverage under this Certificate of Coverage. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

g. Right to a Judicial Review

After you have pursued the first and second level review of an Adverse Decision you have the right to sue in state court, even if you do not request External Review. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

3. Grievance Procedures

a. Definitions. For the purpose of this Grievance Procedures Section, the following term and its definition applies:

Grievance means an oral or written expression of dissatisfaction about something other than a Claim for Benefits (see definition in L.2.a.(4) above).

b. Procedure for Filing a Grievance.

A Grievance is to be submitted to Premier Blue by telephone, in person, or in writing. Premier Blue will acknowledge receipt of the Grievance in writing within 10 working days unless the matter is resolved within that time.

Upon receipt of the Grievance, the Executive Director of Premier Blue (or his/her designee) will conduct a thorough review of the situation within 20 working days unless the review cannot be completed within such time period. If the review cannot be completed within 20 working days after receipt of a Grievance, the Member shall be notified in writing within 30 working days time, and every 30 working days after that, until the review is complete. However, the review must be

completed within 120 days. Following completion of the review, Premier Blue staff not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance. A response to the Member's Grievance will be prepared and the Member will be notified of Premier Blue's decision in writing within 5 working days following completion of the review.

SECTION M. REIMBURSEMENT FOR SERVICES

1. The only payments the Member should expect to make for covered services are the Coinsurance amounts and/or Copayments, as described in the Schedule of Benefits.

2. For covered services which the Member's designated Primary Care Physician provides or arranges for under this Certificate of Coverage the provider of such services will submit to Premier Blue on the Member's behalf claims requesting reimbursement. Premier Blue will make payment to the provider for covered services. The only payments the Member should expect to make for such covered services are any applicable Coinsurance amounts and/or Copayments, as described in the Schedule of Benefits.

3. There will be occasional covered services (such as Out-of-Area Emergency services) where the Member may be required by the provider of service to pay for the service. If the Member then furnishes evidence satisfactory to Premier Blue that he/she has made payment to such provider for a service covered by this Certificate of Coverage, Premier Blue will reimburse the Member directly for the benefits due.

4. Prompt Filing of Claims/Proof of Loss. Notice of the Member's claim must be given to Premier Blue within 90 days after he/she receives services.

   If the Member's provider does not submit a claim, the Member must do so himself/herself. If the Member needs help submitting a claim, he/she should call or write Premier Blue.

   If it is not reasonably possible for the Member to submit a claim within 90 days after he/she receives services, he/she or someone authorized by him/her must submit the claim as soon as reasonably possible. No claim will be paid if not received by Premier Blue within one (1) year and 90 days after services are received.

SECTION N. MISCELLANEOUS

1. **Member Authorizes Premier Blue to Receive Needed Information.** Premier Blue is entitled to receive from any provider of services to Members, information reasonably necessary in connection with the administration of this agreement but subject to all applicable confidentiality requirements. By accepting Coverage under this agreement, the Member authorizes every provider rendering services hereunder to disclose all facts pertaining to such care and treatment and physical condition of the Member to Premier Blue upon request, and render reports pertaining to the same to, and permit copying of records by Premier Blue.

2. **Confidentiality.** Information from medical records of Members and information received from Health Professionals, Hospitals, or any other providers of medical care services incident to the doctor-patient or hospital-patient relationship shall be kept confidential; and, except for use incident to bona fide medical research and education, or reasonably necessary in connection with the administration of this Agreement, may not be disclosed without the consent of the Member.

3. **Applications and Statements.** Members or applicants for membership shall complete and submit to Premier Blue such applications, or other forms or statements, as Premier Blue may reasonably request. The only statements that a Member makes that may be used in any legal action concerning the Certificate of Coverage issued thereunder are statements that are in writing and that are attached to the Certificate of Coverage. Any such written and attached statement will be considered a representation and not a warranty.

4. **Legal Action.** No action at law or in equity shall be brought to recover on the Contract unless brought within five years of the date the loss is incurred.

5. **Notices.** Notices to be given Premier Blue should be addressed to Premier Blue, P.O. Box 3518, Topeka, Kansas 66601-3518. Notices from Premier Blue to the Group will be addressed to the Group at the Group's latest address on Premier Blue's records. Notices from Premier Blue to a Member will be addressed to the Member at the Member's latest address on Premier Blue's records.

6. **Group Information.** The Group agrees to provide Premier Blue with electronic lists of Group members in a form and including such data as mutually acceptable to the Group and Premier Blue. The Group shall notify Premier Blue of any changes in employment and/or other status of Members and their covered dependents which may effect eligibility for coverage hereunder. Such notification shall be provided to Premier Blue within sixty (60) days of the status change date. Premier Blue shall not be liable for any clerical errors or omissions made by the Group which result in extensions of benefits to an ineligible Member or dependent or in the denial of benefits to an eligible Member or dependent. Premier Blue shall not be liable or chargeable for any claims paid as a result of any such error or omission. Notwithstanding the foregoing and independent of fault, Premier Blue shall make a diligent effort to recover overpayments or other payments made in error, but may not initiate legal proceedings against a Member for any such recovery without notifying the Group in writing thirty (30) days prior to initiating any legal or collection action. Coverage under this Contract shall in no event be invalidated by the inadvertent failure of the Group, due to clerical error, to record or report the Member as subject to Coverage.

7. **Disaster Limitation.** To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Premier Blue results in the facilities, personnel, or financial resources of Premier Blue being unavailable to provide or arrange for the provision of covered services, Premier Blue shall make a good faith effort to provide or arrange for the provision of such services taking into account the impact of the event. In such an event Premier Blue and Contracting Providers shall render Hospital and Medical Services provided under this Certificate of Coverage in so far as practical and according to their best judgment, but Premier Blue and Contracting Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by such an event.

8. **Claims Recoveries**

   There may be circumstances in which Premier Blue recovers amounts paid as claims expense from the

provider of service, from the Member or from a third party. Such circumstances include rebates paid to Premier Blue by pharmaceutical manufacturers based upon amounts of claims paid by Premier Blue for certain specified pharmaceuticals, amounts recovered by Premier Blue from health care providers or pharmaceutical manufacturers through certain legal actions instituted by Premier Blue relating to the claims expense of more than one Member, recoveries by Premier Blue of overpayments made to health care providers or to Members, and recoveries from other parties with whom Premier Blue contracts or otherwise relies upon for payment or pricing of claims. The following rules govern Premier Blue's actions with respect to such recoveries:

a. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Copayment or Coinsurance paid by a Member and Premier Blue shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Copayments and Coinsurances for a Member will be adjusted if affected by the recovery.

b. Such recoveries (except for recoveries made within a year and 90 days of the date of the error by Premier Blue of overpayments to health care providers or to Members by Premier Blue not involving assertion of a mass claim by Premier Blue) will not be applied for the purpose of group rating, in any event. The cost actually paid by Premier Blue to procure such recoveries will be treated as an administrative expense in considering group rating. The amounts of recovery available in any event to be applied to the group claims expense will be reduced by the cost to Premier Blue to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities, where such entities obtain recoveries on a contingency basis.

c. If such recovery amounts to less than $500 attributable in any Benefit Period (the period of time in which the Copayment or Coinsurance is calculated) for any Member, no adjustments in Copayments or Coinsurances will be made and Premier Blue shall be entitled to retain such recoveries for its own use.

d. In the event Premier Blue receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by Premier Blue for certain specified pharmaceuticals, Premier Blue shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Contract Holder, to Copayments or to Coinsurances paid by a Member, or to other cost-sharing or claims amounts.

e. If a Member is no longer covered by Premier Blue at the time any such recovery is made, regardless of the amount or of the time of such recovery, Premier Blue shall be entitled to retain such recovery for its own use.

f. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of Premier Blue or otherwise, no adjustments will be made to any Copayment or Coinsurance amounts paid by the Member and Premier Blue shall be entitled to retain such recovery for its own use.

g. The amount of any recoveries which are otherwise available for adjustments to Copayments or Coinsurances will be reduced by the cost to Premier Blue to procure that recovery, consisting of amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis.

9. BlueCard

Benefits are not available for covered services unless the following criteria is met. All services require prior authorization by the Member's Primary Care Physician if not performed, prescribed, ordered, or arranged by the Member's designated Primary Care Physician in effect at the time services are provided unless otherwise stated in the Certificate of Coverage.

When you obtain health care services through BlueCard outside the geographic area the Company serves, the amount you pay for covered services is calculated on the **lower** of:

- the billed charges for your covered services, or
- the negotiated price that the on-site Blue Cross and/or Blue Shield Company ("Host Blue") passes on to us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specific group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Insured liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Insured liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Company would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

If you would like to know the specific basis used for calculating Insured liability for covered services received outside the Company Service Area, you may contact the Blue Cross and Blue Shield of Kansas Customer Service Center.

10. Obtaining Additional Information

For additional information regarding the benefits covered hereunder or to obtain a copy of the list of Contracting Providers that when used will assure that

you are receiving the highest possible level of benefits available under this Certificate of Coverage, call the customer service center phone number on your Identification Card. Information you request about benefits and lists of Contracting Providers will be furnished without charge. Additional information can also be found on the website.

12. Certificate of Creditable Coverage. You have the right to request and obtain a Certificate of Creditable Coverage from Premier Blue while you are a Member and up to 24 months following the date on which your coverage cancelled. To request a Certificate of Creditable Coverage contact the customer service center phone number on your Identification Card.

SECTION O. SCHEDULE OF BENEFITS

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

1. BENEFIT PERIOD

The time period that begins yearly at 12:01 am on January 1 and ends at midnight on December 31.

2. AMOUNT OF COPAYMENT AND COINSURANCE

Benefits are not available for covered services unless the following criteria is met. All services require prior authorization by the Member's Primary Care Physician if not performed, prescribed, ordered, or arranged by the Member's designated Primary Care Physician in effect at the time services are provided unless otherwise stated in the Certificate of Coverage. Primary Care Physician authorization is not required for Medical Emergencies and/or the initial treatment for an Out-of-Area Emergency.

HOSPITAL/MEDICAL CARE FACILITY SERVICES	
Inpatient Copayment	The Member will be required to pay a $200 Copayment per Member per admission for Inpatient services. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. This Copayment applies to all admissions including an admission for a Nervous or Mental Condition. A separate Copayment will not be taken on Inpatient Hospital services provided a newborn child as long as the mother is an Inpatient in the Hospital. A Copayment will be taken on Inpatient Hospital services provided a newborn if the mother is dismissed from the Hospital and the newborn remains an Inpatient in the Hospital.
Emergency Facility Services	The Member will be required to pay a $75 Copayment per visit for emergency facility services. The Copayment does not apply if the Member is admitted within 24 hours to a Hospital for Inpatient treatment of that condition. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below.
Outpatient Surgery Copayment	The Member will be required to pay a $100 Copayment per occurrence for Outpatient surgical services. This Copayment also will apply to Ambulatory Surgical Centers. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below.
Skilled Nursing Facility Services	The Member will be required to pay a $200 Copayment per Member per admission for Skilled Nursing Facility services. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. Benefits for Skilled Nursing Facility services are limited to a total of 90 days per Member per Benefit Period.
PHYSICIAN'S SERVICES	
Home or doctor's office visits provided by your PCP, including the initial prenatal visit for maternity care.	The Member will be required to pay a $20 Copayment per home or office visit. Visits for the purpose of receiving injection or treatments where the Member is not seen by a doctor or CNP will not be considered home or office visits. This Copayment does apply to home or office visits provided for a Biologically Based Mental Illness. This Copayment applies only to the charge for the home or office visit. The charge for any service other than the home or office visit (laboratory or radiology or other treatment services) is subject to the payment provisions that apply to the service provided.
Home or doctor's office visits provided by a Health Professional who is not your PCP (a specialist)	The Member will be required to pay a $30 Copayment per home or office visit. Visits for the purpose of receiving injections or treatments where the Member is not seen by a doctor or CNP will not be considered home or office visits. This Copayment does apply to home or office visits provided for a Biologically Based

	Mental Illness. In order for the home or office visit to be eligible for benefits you must be referred by your PCP unless the service does not require PCP referral in which case the home or office visit must be obtained by a Contracting Provider with Premier Blue. This Copayment applies only to the charge for the home or office visit. The charge for any service other than the home or office visit (laboratory or radiology or other treatment services) is subject to the payment provisions that apply to the service provided.
Urgent Care Visit	The Member will be required to pay a $30 Copayment per visit to an Urgent Care Facility. This Copayment applies only to the charge for the urgent care visit. The charge for any service other than the urgent care visit (laboratory or radiology or other treatment services) is subject to the payment provisions that apply to the service provided.
Dietitian Consultation.	Limited to one consultation per year when referred by the Member's PCP. The Member will be required to pay a $30 Copayment. ($20 when provided by the Member's PCP - $30 when referred by the Member's PCP).
Routine Hearing Exam	Limited to one routine hearing exam per year when referred by the Member's PCP. The Member will be required to pay a $30 Copayment. Benefits are **not** available for hearing aids. ($20 when provided by the Member's PCP - $30 when referred by the Member's PCP).
Allergy Testing	Subject to the Coinsurance and Coinsurance Maximum provisions listed below. If there is an office visit charge, that charge is subject to the applicable Office Visit Copayment ($20 when provided by the Member's PCP - $30 when referred by the Member's PCP).
Antigen Administration	Subject to the Coinsurance and Coinsurance Maximum provisions listed below. If there is an office visit charge, that charge is subject to applicable Office Visit Copayment ($20 when provided by the Member's PCP - $30 when referred by the Member's PCP).
Medical Equipment And Supplies	The Allowable Charge for Medical Equipment and supplies is subject to the Coinsurance and Coinsurance Maximum listed below until a maximum of $5,000 of Allowable Charges per Member per Benefit Period has been adjudicated by Premier Blue. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. After the maximum of $5,000 of Allowable Charges has been adjudicated for Medical Equipment, no benefits are available for Medical Equipment until the next Benefit Period. This Medical Equipment maximum does not apply to covered contraceptive devices such as IUD's and diaphragms; oxygen or oxygen equipment; or supplies or equipment used in conjunction with intravenous drug treatment.
Major Diagnostic Tests (Provided on an Outpatient Basis)	The Member will be required to pay a $100 Copayment per test for Major Diagnostic Tests which include the following: PET Scans, MRI Scans, CAT Scans, Nuclear Cardiology Studies, MRA (magnetic resonance angiography), and CTA (computed tomographic angiography). One Copayment will be applied for all like services provided on the same day (i.e. all CT's provided on the same day will be subject to one Copayment, all MRI's provided on the same day will be subject to one Copayment). If CT's and MRI's (or any of the other types of Major Diagnostic Tests) are provided on the same day, there will be one Copayment applied to all of the CT's and one Copayment applied to all of the MRI's (or other types of Major Diagnostic Tests) – the Member will be responsible for two Copayments. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. In order for the tests to be eligible for benefits you must be referred by your PCP.
Preventive Services	The following services are payable at 100% of the Allowable Charge when provided by a Contracting Provider with Premier Blue or by the Member's PCP (this benefit is for one routine physical per Member per Benefit Period and the preventive diagnostic services listed below that are provided in conjunction with that one routine physical): One routine physical examination or one well child examination One routine eye examination One pap smear per year when provided at the time of a well woman exam. One routine mammogram per year. STD testing when provided at the time of a well woman exam or a well man exam, limited to once per year. One PSA blood test per year when provided at the time of a well man exam. One age-appropriate bone density screening per year (PCP authorization is required). One routine age-appropriate colonoscopy per Member per lifetime (PCP authorization is required). Standard diagnostic tests provided in connection with a periodic physical exam to include: General Health Panel Comprehensive Metabolic Panel

	Lipid Panel Urinalysis (UA) Fecal Occult Blood Cholesterol Creatinine HDL Cholesterol Thyroid Stimulating Hormone Triglycerides Complete Blood Count (CBC)
Childhood Immunizations:	Benefit payments will be made at 100% of the Allowable Charge for a covered newborn from birth to 72 months of age for the following immunizations: at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib) and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella; and such other vaccines and dosages as may be prescribed by the secretary of health and environment.
HOME HEALTH CARE	The Allowable Charge for home health care will be subject to the Coinsurance and Coinsurance maximum provisions listed below until a maximum of $5,000 of Allowable Charges per Member per Benefit Period has been adjudicated by Premier Blue. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. After the maximum of $5,000 of Allowable Charges has been adjudicated for home health care no benefits are available for home health care until the next Benefit Period. In order for home health care to be eligible for benefits you must be referred by your PCP. Home health care should also be prior authorized by Premier Blue. To obtain prior authorization, your Physician must provide appropriate records to Premier Blue prior to providing services and Premier Blue will authorize coverage if the Medical Necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if Medical Necessity is supported when the claim is adjudicated.
HOSPICE CARE	The Allowable Charge for hospice will be subject to the Coinsurance and Coinsurance maximum provisions listed below until a maximum of $7,500 of Allowable Charges per Member per lifetime has been adjudicated by Premier Blue. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. After the maximum of $7,500 of Allowable Charges has been adjudicated under the hospice care provision, services will be processed according to the benefits and limitations of this Certificate of Coverage other than those listed in the hospice care provision. In order for hospice care to be eligible for benefits you must be referred by your PCP. Hospice care should also be prior authorized by Premier Blue. To obtain prior authorization, your Physician must provide appropriate records to Premier Blue prior to providing services and Premier Blue will authorize coverage if the Medical Necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if Medical Necessity is supported when the claim is adjudicated.
REHABILITATION SERVICES	
Facility Based Rehabilitation Services	Inpatient Services - The Member will be required to pay a $200 Copayment per Member per admission for Inpatient Rehabilitation Services. After the Copayment has been met, benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below. To be eligible for benefits services require authorization by the Member's PCP and Premier Blue; must be Medically Necessary; appropriate; result in continuous improvement and are not custodial Outpatient Services (in facilities such as Kansas Rehab Hospital) – Benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below for services that are Medically Necessary, appropriate and result in continuous improvement.
Office Based Rehabilitation Services	Office Based Rehabilitation Services– Benefits will be paid at 90%. The 10% Coinsurance paid by the Member accumulates toward the Coinsurance Maximum listed below for services that are Medically Necessary, appropriate and result in continuous improvement. Office Based Rehabilitation Services are limited to a maximum of 30 visits per Member per Benefit Period. Modalities and Manipulations - The Member will be required to pay a $30 Copayment per visit when a Modality or Manipulation (as defined in Section A DEFINITIONS) is provided but an office visit is not provided. This Copayment applies only to the charge for the Modality or Manipulation. The charge for any service other than the Modality or Manipulation (laboratory or radiology or other treatment services) is subject to the payment provisions that apply to the service provided. If an office visit is provided the Member will be responsible for $20 when provided by the Member's PCP - $30 when referred by the Member's PCP. The number of Modalities and Manipulations is combined with the number of Office Based Rehabilitation Services to meet the maximum of 30 visits per Member per

	Benefit Period. After the maximum of 30 visits per Member per Benefit Period has been met, benefits are not available for Office Based Rehabilitation Services or Modalities and Manipulations for the remainder of that Benefit Period.
COINSURANCE	After any applicable Copayment has been met, payment will be made at 90% of the remaining Allowable Charge unless otherwise noted.
COINSURANCE MAXIMUM	When the amount you have paid in Coinsurance (your 10% of the Allowable Charge after the application of any Copayment) in the Benefit Period reaches $1,000 for any one Insured or $2,000 for all Members on Family Coverage (in aggregate), the amount payable for the rest of the Benefit Period will be 100% of the Allowable Charges (Copayments still apply). Any amounts you pay in Copayments **do not** apply toward the Coinsurance Maximum.
MAXIMUM BENEFIT LIMIT	The lifetime Maximum Benefit Limit under this Certificate of Coverage is $3,000,000 or each Member.
MEDICARE ELIGIBILITY	If you or one of your Dependents is eligible for Medicare benefits and Medicare is or would be primary payor for the individual's coverage as specified by applicable law, they must be enrolled in Medicare Part A (Hospital) and Part B (Medical). If they do not enroll in Medicare Part A and Part B, the benefits of this Certificate of Coverage will be determined as if they were enrolled in Medicare Part A and Part B. This means that this Certificate of Coverage will only pay the amount that would be paid if Medicare had made payment and you would be responsible for the amount that Medicare would have paid

SECTION P. COVERED HEALTH SERVICES

Members holding Coverage are entitled to receive the services set forth in this Section. **Benefits are not available for covered services unless the following criteria is met. All services require prior authorization by the Member's Primary Care Physician** if not performed, prescribed, ordered, or arranged by the Member's designated Primary Care Physician in effect at the time services are provided unless otherwise stated in the Certificate of Coverage. Primary Care Physician authorization is not required for Medical Emergencies and/or the initial treatment for an Out-of-Area Emergency.

1. **Medical Services** (including those services provided for a Biologically Based Mental Illness)

   Medical, surgical, anesthesia, diagnostic, therapeutic, and preventive services are provided.

   Medical services include home and office calls, medical eye examinations, injections (Injections include the prescription drug being injected. In the case of allergy antigens, the antigen itself is covered whether injected by a Physician or provided to the Member for self-administration.), consultations, and medical services received as a Hospital Inpatient/Outpatient or as an Inpatient in a Skilled Nursing Facility.

   Preventive services include well child care from birth, periodic health evaluations, ear examinations to determine the need for hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

   Well woman care will be covered without the Member's designated Primary Care Physician having ordered or referred the Member as long as the services are obtained from a Contracting Provider with Premier Blue. Well woman care includes the following routine services per Benefit Period: one gynecological examination, one pap smear, one mammogram, and screening tests for sexually transmitted diseases when provided at the same time as the well woman examination.

   Well man care will be covered without the Member's designated Primary Care Physician having ordered or referred the Member as long as the services are obtained from a Contracting Provider with Premier Blue. Well man care includes the following routine services per Benefit Period: one office visit and one PSA blood test.

   Family planning consultations, fertility consultations, and sterilization consultations are provided. Sterilization procedures and sterilization consultations are covered without the Member's designated Primary Care Physician having ordered or referred the Member. However, the Member must (1) notify Premier Blue of the need for such service, and (2) obtain such services from a Contracting Provider with Premier Blue.

   One routine eye examination per Member per Benefit Period to determine the need for vision correction will be a covered health service without the Member's designated Primary Care Physician having ordered or referred the Member as long as the services are obtained from a Contracting Provider with Premier Blue.

2. **Hospital and Skilled Nursing Facility Services**

   a. Admissions to a Hospital or Skilled Nursing Facility, including those for Biologically Based Mental Illness, for Inpatient services, beginning on or after the date this Certificate of Coverage becomes effective for the Member, are provided and include when applicable: Semi-private room and board (or private room when Medically Necessary as determined by the Member's designated Primary Care Physician), general nursing care, meals and special diets when Medically Necessary; use of operating room and related facilities; use of intensive care unit; radiology services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, radiation therapy, chemotherapy, administration of whole blood and blood plasma; special duty nursing when Medically Necessary. The cost or replacement of whole blood and payments to donors of blood are not provided.

   This provision includes coverage for the delivery expense of the birth mother of a child adopted and added to Coverage within 90 days of birth of such child.

   Note: Pursuant to Federal and state law, covered Inpatient services are available for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for a mother and newly born child in a Hospital as long as the membership type otherwise includes

Coverage for the mother and/or children. This requirement does not prevent the Health Professional and the Member from deciding to shorten the Inpatient stay. Premier Blue has the right to determine the Medical Necessity of additional coverage (beyond the 48-96 hours described above) for a mother and for the child. In the event that Coverage hereunder provides benefits for only the mother of the newly born child, Coverage must be changed to a type that provides benefits for Dependent children within the time period required for such change (as set forth in the Enrollment and Effective Dates Section), for Inpatient services to be available for the newborn child(ren) beyond the initial 48 or 96 hour periods described above. Covered services received by the child prior to Coverage being changed to a type that provides benefits for Dependent children, will be treated as though they were services received by the mother and any Coinsurance or Copayment/Copay amounts otherwise applicable to the mother will be applied to expenses of the child.

b. Covered Hospital Services for mental health conditions, other than Biologically Based Mental Illness, are set forth in item c.1, of paragraph 5 (Mental Health Services).

c. Convalescent Care, Custodial/Maintenance Care, or Rest Cures is not provided. Also, domiciliary care and care or treatment of a mental health condition in a Skilled Nursing Facility is not provided.

d. Benefits for Skilled Nursing Facility services are limited to a total of 90 days per Member per Benefit Period.

3. Prostheses, Orthopedic Appliances, Medical Equipment

Coverage is provided for external or surgically implanted prostheses (items that replace all or part of a human body part) including repair and maintenance thereof except as limited below; for orthopedic appliances, subject to the limitations below; and for rental of medical equipment for use in the patient's home, subject to the limitations below. Only those prostheses, orthopedic appliances, and medical equipment that are Medically Necessary are provided. Coverage is available for breasts prostheses following a mastectomy. Benefits are limited to 2 prostheses per breast per Member per Benefit Period.

Coverage is also available for certain supplies, excluding diabetic supplies eligible for coverage under a Prescription Drug Expense Program sponsored by the Group, as designated by Premier Blue. A list of eligible supplies will be maintained by Premier Blue.

Limitations:

a. Prosthetic devices will be limited to the initial surgically implanted device. Penile implants are only covered when required as a result of diabetes or other medical conditions. There will be a maximum of one implant per lifetime which is a covered benefit, unless the prosthetic device or appliance is no longer suitable due to continued growth and/or development, providing the original prosthetic device or appliance was originally provided to a child.

b. Coverage for post-mastectomy bra/camisole/softee limited to a combination of 2 (either 2 bras or 2 camisoles or 2 softees or 1 bra and 1 camisole or 1 bra and 1 softee or 1 camisole and 1 softee) per Member per Benefit Period (a post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral prostheses). Premier Blue has the right to decide whether to provide for the rental or purchase of a covered piece of medical equipment and apply rental payments to purchase. Premier Blue also has the right to stop providing rental when the item is no longer Medically Necessary.

c. Benefits are **not** provided for: eyeglasses or contact lenses except for the initial purchase (within 6 months following surgery for cataracts, aphakia, or pseudophakia). An Insured under 12 years of age is eligible to receive benefits for the initial eyeglasses/contacts following surgery for cataracts and for subsequent eyeglasses/contacts when there is a diopter change of .25 diopter until they reach the age of 12 years.

d. Benefits are also not provided for arch supports, shoe lifts or other orthotics; corsets; non-custom made elastic hose; corrective shoes; special appliances; dressings, hair prostheses; dental plates, bridges, or any dental prosthesis, or for dental braces, items of wearing apparel; items that do not serve a medical purpose. Items for comfort or convenience are not provided.

e. Benefits are limited to the amount normally available for a basic (standard) item which allows necessary function.

f. Charges for deluxe or electrically operated external prostheses orthopedic appliances, or medical equipment are not covered, beyond the extent allowed for basic (standard) items.

g. The benefit for an electrically operated wheelchair will be the amount normally available for a hand-operated wheelchair.

4. Maternity Care

The initial visit to determine the existence of a pregnancy does not require authorization from the Member's Primary Care Physician if the services are obtained from a Contracting Provider with Premier Blue.

No prior authorization from the Member's designated Primary Care Physician is needed for maternity care services including pre and post partum care if the services are obtained from a Contracting Provider with Premier Blue

ANY SERVICE NOT RELATED TO THE PREGNANCY MUST BE PERFORMED OR AUTHORIZED BY THE MEMBER'S DESIGNATED PRIMARY CARE PHYSICIAN.

This provision includes coverage for the obstetrical and delivery expense of the birth mother of a child adopted and added to Coverage within 90 days of birth of such child. These services will be eligible for benefits even if they are not provided by a Contracting Provider with Premier Blue.

Abortion Coverage:

a. Abortions and abortion related services will be covered in the following:

(1) Where the life of the mother would be endangered if the fetus were carried to term;

(2) Termination of a tubal pregnancy;

(3) Prior to the eighth week of pregnancy, if the pregnancy is the result of an act of rape or incest; or

b. Medical complications that have risen from an abortion will be covered.

5. Mental Health Services

a. Referral Requirements

Mental Health Services including those provided for a Biologically Based Mental Illness must be authorized by the Exclusive Provider of Psychiatric or Psychological Services. To obtain the required authorization call toll free 1-800-643-6154. The Member's designated Primary Care Physician cannot authorize Mental Health Services.

b. Definitions

In addition to any previously defined terms, the following definitions are added for the purposes of this Mental Health Services section.

(1) Mental Illness means any disorder which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. Biologically Based Mental Illnesses are not included in this definition of Mental Illness.

(2) Nervous or Mental Condition. Nervous or Mental Condition means a disorder specified in the current Diagnostic and Statistical Manual of the American Psychiatric Association. Those shown as "not attributable to a mental disorder that are a focus of attention or treatment" are not covered.

(3) Hospital. Solely for the purpose of this Mental Health Services provision, Hospital shall mean a Medical Care Facility licensed under KSA 65-429, a treatment facility for alcoholics licensed under KSA 65-4014, a treatment facility for drug abusers licensed under KSA 65-4605, a community mental health center or clinic licensed under KSA 75-3307b, or a psychiatric hospital licensed under KSA 75-3307b.

(4) "Exclusive Providers of Psychiatry or Psychological Services" means those persons from whom Premier Blue has agreed to purchase services for Nervous or Mental Conditions, drug abuse, and alcoholism.

c. Services Provided

(1) Inpatient services. Inpatient services and Medical Services (as defined herein) while confined to a Hospital for all Nervous or Mental Conditions, other than a Biologically Based Mental Illness, combined are limited to a total of 60 days per Member in any one Benefit Period.

Medical Services are limited to either one routine medical visit or one psychiatric service each day, but not both.

Each day of the available sixty (60) days will be exchanged with partial hospitalization sessions in an approved partial day facility of not less than three (3) hours and not more than twelve (12) hours in any twenty-four (24) hour period, based upon the following exchange formula; If the charge for one partial hospitalization session does not exceed fifty (50) percent of the Allowable Charge for one Inpatient day of the average semi-private rate at the Contracting Provider where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day of Inpatient care. If the charge for one partial hospitalization session does exceed fifty (50) percent of the Allowable Charge for one Inpatient day of the average semi-private rate at the Contracting Provider where the session is conducted, the benefit exchange will be one partial hospitalization session equal to one day of Inpatient care.

(2) Outpatient Services. Outpatient services for all Nervous or Mental Conditions, other than a Biologically Based Mental Illness, combined are provided for each Member per Benefit Period, when service is obtained from a Hospital or from a Physician, a certified psychologist, or a licensed specialist clinical social worker as follows:

The first three (3) Outpatient visits will be covered at 100% of the Allowable Charge. The next twenty-two (22) visits will be covered at 100% of the Allowable Charge after a $25 Copayment per visit. Additional visits during the Benefit Period will be paid at 50% of the Allowable Charge.

Note: In the case of group counseling sessions, benefits would be available as follows: the first six (6) sessions will be covered at 100% of the Allowable Charge. The next forty-four (44) sessions will be covered at 100% of the Allowable Charge after a $12.50 Copayment per session. For the purposes of determining maximum Outpatient benefits, each two group counseling sessions will reduce the total number of Outpatient visits available by one (1) visit. Likewise, each Outpatient visit will reduce the number of available group counseling sessions by two (2) sessions. Additional visits during the Benefit Period will be paid at 50% of the Allowable Charge.

Any amount the Member is required to pay for Outpatient Nervous or Mental services does not accumulate toward the Coinsurance Maximum.

d. Clarifications and Exclusions

(1) Care or treatment of a Nervous or Mental Condition in a Skilled Nursing Facility is not eligible for benefits.

(2) Assessment required by a diversion agreement, court ordered attendance at a drug or alcohol safety action program, or court ordered treatment for alcoholism or drug abuse or a Nervous or Mental Condition are not eligible for benefits.

(3) Evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings are not eligible for benefits.

e. Limitations

Services for Nervous or Mental Conditions are available only as described in item a. of this Mental Health Services provision. This includes court-ordered admissions and involuntary treatment of any kind.

6. Emergency Services

Emergency Services means Ambulance Services and health care items and services furnished or required to evaluate and treat a Medical Emergency including emergency services necessary to provide a Member with a medical examination and stabilizing treatment for a Medical Emergency.

Primary Care Physician authorization is not needed for Emergency Services. However, you should notify your Primary Care Physician as soon as reasonably possible after receipt of such services, or if treatment in addition to the medical examination and stabilizing treatment is required.

7. Outpatient Non-Emergency Services

Diagnostic services, treatment services, and radiology services for patients who are ambulatory and receive such services in a Hospital Outpatient department or in a non-hospital based facility that provides such services are provided. This includes services provided for a Biologically Based Mental Illness.

8. Covered Rehabilitation Services.

Except as limited, the following Rehabilitation Services (including chiropractic care) that are Medically Necessary, appropriate; and result in continuous improvement are covered on both an Inpatient and Outpatient basis when provided on or after the date the Member becomes covered by this Certificate of Coverage;

a. Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance, distortion, subluxation or misplaced tissue of any kind or nature of the human body.

b. Physical therapy.

c. Occupational therapy. (The materials used are excluded.)

d. Speech therapy.

e. Respiratory therapy.

f. Neuropsychological testing.

g. Cardiac rehabilitation.

h. Pulmonary rehabilitation.

Note: (Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by Premier Blue).

In addition to the above, Premier Blue, at its sole discretion, may approve the payment of benefits for Rehabilitation Services that are received in an institution other than a Hospital. In order to obtain these discretionary benefits for Rehabilitation Services, Premier Blue and your designated Primary Care Physician must authorize such benefits prior to receipt of such services. Premier Blue has the right to request and obtain whatever information it considers necessary to determine the appropriateness of such services. Such information may include but not be limited to, the condition of the Member for which treatment is being requested, data indicating the charging practices of the facility in which treatment is being contemplated, and a written report of the recommended measurable treatment, goals, and expected outcome, including the proposed fees for the entire course of treatment. This information must be received by Premier Blue before services are rendered. If such services are deemed appropriate by Premier Blue, Premier Blue will notify the Member, the facility, the Primary Care Physician and the admitting Physician of approval.

Limitations:

a. Prior Authorization Requirement: Inpatient admissions for Rehabilitation Services made to a Hospital or another institution as allowed for above, that occur on or after the date the Member becomes covered by this Certificate of Coverage require prior authorization by Premier Blue and your designated Primary Care Physician.

Premier Blue has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, Premier Blue will notify the Member, the institution, the Primary Care Physician and the admitting Physician of approval. If Inpatient admission is not deemed Medically Necessary, the Member will be notified, as well as the institution and the admitting Physician. Prior authorization of an admission or any service is related solely to the Medical Necessity of the service and is not a determination of the eligibility of the service under other provisions of this Certificate of Coverage.

b. Second Opinions:

Premier Blue has the right to require the Member to obtain a second opinion regarding the appropriateness of the Rehabilitation Services being provided, from a provider of Premier Blue's choice. Premier Blue will be entirely responsible for the costs associated with such a second opinion; however, such amounts will not be applied toward the satisfaction of any Copayment or Coinsurance amounts otherwise required by this Certificate of Coverage.

Exclusions:

a. Convalescent Care, Custodial/Maintenance Care or Rest Cures.

Premier Blue will determine which services are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

b. Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

c. Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or reinjury.

d. Cognitive therapy. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, inability to scan visually. Cognitive services may also be known as multi-sensory programs, applied

behavioral analysis, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy, or another name.

For the purposes of this Certificate of Coverage cognitive services have no correlation to neuropsychological testing.

9. Diagnostic Radiology and Laboratory Services

Diagnostic radiology services and laboratory services in support of basic health services are provided.

10. Therapeutic Radiological Services

Therapeutic radiological services (such as X-ray therapy, cobalt therapy) are provided.

11. Oral Surgery and Other Related Benefits

Premier Blue will pay for the following limited dental services:

a. Administration of general anesthetic and facility charges determined by Premier Blue to be Medically Necessary for dental care, and provided to the following persons:

(1) Dependent children five years of age or under; or

(2) A Member who is severely disabled; or

(3) A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

b. Benefits for oral surgical procedures of the jaw or gums will be covered for:

(1) Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(2) Removal of symptomatic exostoses (bony growths) of the jaw and hard or soft palate;

(3) Treatment of fractures and dislocations of the jaw and facial bones;

(4) Laceration of mouth, tongue or gums;

(5) Intraoral x-rays and pathology services in connection with covered oral surgery; and

(6) General anesthetic for covered oral surgery.

Note: All claims for treatment of accidental trauma to sound natural teeth should be processed by the State's dental plan. Services covered by the State's dental plan are not eligible for additional payment by the medical plan.

Exclusions: You do not have coverage for any service eligible for benefits under your dental care program sponsored by the underwriter of your dental program.

No coverage is available for the removal of impacted teeth or any services related to the removal of impacted teeth, dental implants, treatment of periodontal disease, temporomandibular joint dysfunction syndrome (TMJ) or othognathic procedures.

12. Home Health Services

The following items and services will be provided in the Member's home by, or under the supervision of, a professional nurse on a part-time or intermittent basis when prescribed and periodically reviewed by the patient's Primary Care Physician: nursing care, short-term Rehabilitative Services (subject to the limitations that apply to short-term Rehabilitation Services, medical social services, medical supplies (other than drugs and biologicals that are available under the prescription drug program sponsored by the Group); and other Medically Necessary services and supplies which are prescribed by the patient's Primary Care Physician and which are not excluded under this Certificate of Coverage.

13. Hospice Care

Election of Hospice Benefits

In order for a Member to receive Hospice benefits for the covered services listed below, Premier Blue must receive a copy of the Hospice Election Form and the Informed Consent Form from the Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services the Member receives will be processed according to the benefits and limitations of this Certificate of Coverage other than those listed in this Hospice Care provision.

All Hospice Care services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under the Benefit Description.

Eligibility of Services

a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If Premier Blue determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Member is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Health Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision the services will be processed according to the benefits and limitations of this Certificate of Coverage other than those listed in this Hospice Care provision.

Covered Services

Covered Hospice care includes services provided by a Medicare certified Hospice or other facility or professional provider under the direction of a Medicare certified Hospice and not charging for services separately from the charges made by the Hospice.

Covered services include the following when provided for routine home care according to the Hospice Care Plan and provided by the Hospice for the Terminal Illness:

a. Nursing care.

b. Home health aide services.

c. Social work services.

d. Pastoral services.

e. Volunteer support.

f. Bereavement services.

g. Counseling services.

h. Dietary and nutritional counseling/services.

i. Drugs (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Group), medical supplies, and equipment related to the terminal illness.

j. Speech therapy.

k. Occupational therapy.

l. Physical therapy.

m. Lab fees.

n. Medical equipment.

o. Educational services.

p. Professional services of a Physician.

q. Other services and supplies provided through the Medicare certified Hospice recommended by a Doctor.

14. Ambulance Service

Except as limited, Ambulance Service that is Medically Necessary is covered to the place of treatment following a Medical Emergency, to a Hospital for hospital care as an Inpatient, from a Hospital where you have been an Inpatient, or for transfer of an Inpatient to another Hospital for care as an Inpatient.

Ambulance Service benefits are limited to the Allowable Charges that are within a 500-mile radius of the place where you are picked up, by the least expensive means that meets the medical need.

15. Health Education

Health education services and education in the appropriate use of the Premier Blue services are provided when organized or conducted by Premier Blue or when provided in the Member's Primary Care Physician's office. Health education services include instructions on achieving and maintaining physical and mental health and preventing illness and injury.

16. Human Organ and Human Tissue Transplants.

Benefits are provided (subject to the prior authorization provision set forth below) for the following human organ transplants: Cornea; heart; heart-lung; kidney; pancreas; liver; lung (single or double). There is no coverage hereunder for any transplants not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

Benefits including hospitalization and surgery, for a human organ transplant will be available for a live donor (whether or not a Member), if the recipient is a Member, unless the donor has other coverage.

Benefits are also available for organ procurement costs limited to costs directly related to the procurement of an organ from a cadaver. Organ procurement costs include organ transportation, compatibility testing, and donor transportation.

Transportation and lodging costs for the Member and one family member will be provided if the transplant is performed outside of the Premier Blue Service Area or when the Member resides more than fifty (50) miles from the transplant site. Travel expenses shall be defined as commercial transportation of the Member receiving the transplant and a companion, to and from the site of the transplant. Reasonable and necessary lodging and meal costs, limited to $125 per day, incurred by the companion and Member during the Transplant Benefit Period are included. Associated travel expenses are limited to a maximum benefit of $5,000 per Transplant Benefit Period. The Transplant Benefit Period shall mean the period 24 hours prior to the hospitalization for the transplant procedure, through a 48 hour maximum travel period after the Member's discharge.

Prior Authorization Requirement for Human Organ or Human Tissue Transplants:

Benefits for the covered transplants (except benefits for cornea transplants), transportation and lodging costs for the Member and one family member, require advance written authorization from Premier Blue. The Member or their Doctor must give written notice to Premier Blue at such time as you become a candidate for a human organ transplant or re-transplant. Premier

Blue has the right to require, request and obtain information from the Member's doctors and other health care providers who will be involved in the performance of the transplant or re-transplant, and to then determine whether or not to authorize benefits.

Premier Blue's determination of whether or not to authorize benefits will be based on factors such as (but not limited to): qualifications of the facility where the procedures are to be performed; qualifications of the Doctors to be involved in the performance of the procedures; comparative costs of the doctors to perform the procedures, the facility in which the procedures are proposed to be performed, and other factors. Notwithstanding any other provisions in this document addressing Allowable Charges to the contrary, Premier Blue reserves the right to limit its allowance to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that has agreed to contract with Premier Blue to provide these services. Any balance will be the obligation of the Subscriber.

17. High-Dose Chemotherapy with Hematopoietic Support (Commonly Referred to as bone marrow transplant and/or Peripheral Stem Cell Transplant). The benefits of this paragraph are available only when precertified by Premier Blue, and the condition for which the treatment is being proposed would not render the treatment non-covered through application of the Experimental or Investigational definition.

The benefits for the costs associated with the donor search and acquisition of bone morrow or peripheral stem cells when a related donor is not available is limited to $35,000 per Member per transplant.

Prior Authorization Requirement for High-Dose Chemotherapy with Hematopoietic Support:

Benefits for hematopoietic support with High-Dose Chemotherapy, require advance written authorization from Premier Blue. The Member or their Doctor must give written notice to Premier Blue at such time as you become a candidate for the hematopoietic support with High-Dose Chemotherapy procedure. Premier Blue has the right to require, request and obtain information from the Member's doctors and other health care providers who will be involved in the performance of the hematopoietic support with High-Dose Chemotherapy procedure, and to then determine whether or not to authorize benefits. Premier Blue's determination of whether or not to authorize benefits will be based on factors such as (but not limited to): qualifications of the facility where the procedures are to be performed; qualifications of the Doctors to be involved in the performance of the

procedures; comparative costs of the doctors to perform the procedures, the facility in which the procedures are proposed to be performed, and other factors. Notwithstanding any other provisions in this document addressing Allowable Charges to the contrary, Premier Blue reserves the right to limit its allowance to the lowest allowable acquisition cost which would be accepted by another facility that has agreed to contract with Premier Blue to provide these services. Any balance will be the obligation of the Subscriber.

18. **Case Management** services are covered as defined in Section A. Definitions.

19. **Research-Urgent Benefits** are covered as defined in Section A. Definitions.

20. **Chemotherapy** (chemical treatment) for malignant conditions.
    - **a.** Your Doctor's services for administering chemotherapy.
    - **b.** The chemotherapy drugs that are injected or given intravenously or taken by mouth during the course of a professional treatment administered by your doctor (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Group).

21. **Services associated with intravenous drug treatment including intravenous drugs, administration sets, and equipment** authorized by the Member's Primary Care Physician.

    Prior Authorization: To obtain prior authorization for Total Parenteral Nutrition, Intravenous Antibiotics for Lyme Disease, or other prescription drugs associated with intravenous drug treatment your Physician must provide appropriate records to Premier Blue prior to providing services and Premier Blue will authorize coverage if the Medical Necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if Medical Necessity is supported when the claim is adjudicated.

22. **Nutritional Evaluation**

    Initial nutritional evaluation or the initial counseling from a Contracting Provider will be provided when diet is part of the medical management of a documented disease, including morbid obesity.

23. **Artificial insemination** will be covered subject to a maximum of three billable attempts per Benefit Period. There is no coverage for donor fees, collection and/or storage of sperm or any other donor related services. Prescription drugs provided in connection with infertility are not covered.

24. **Diabetic Coverage.** Coverage is only provided for the following when provided by or upon referral from your Primary Care Physician and not eligible for coverage under a Prescription Drug Expense Program sponsored by the Group:
    - **a.** Equipment, including glucometers, limited to those used exclusively with diabetes management; and
    - **b.** Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association; (2) is treated by a person certified by the national certification board for diabetes educators; or (3) is treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional for nutritional education.
    - **c.** An annual retinal exam for Members with diabetes is eligible for benefits without the Member's designated Primary Care Physician having ordered or referred the Member as long as the services are obtained from a Contracting Provider with Premier Blue.

    Coverage for diabetes equipment is not subject to the Medical Equipment Benefit Period Maximum.

25. **Health Management Benefits** is a program approved by Premier Blue and conducted by the Premier Blue case manager for specific chronic conditions as determined by Premier Blue which:
    - **a.** Identifies at risk Members with the specific chronic condition and
    - **b.** Provides interventions approved by the case manager to maintain or improve the Member's health status to avoid complications from the chronic disease**.**

    The program may include both covered and non-covered services with the exception of specifically stated exclusions. Benefits for those services cannot exceed the lifetime benefit maximum under the Member's Coverage. If such written approval is granted, payment for benefits under this policy for such services or supplies shall be on the same basis as if such services or supplies were Covered Services under the terms and provisions of this Certificate of Coverage.

    PROVIDED, HOWEVER, THAT NO COVERED PERSON IS REQUIRED, IN ANY WAY WHATSOEVER, TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE CASE MANAGER.

26. Injectable prescription drugs are eligible for coverage under this Certificate of Coverage if they are not eligible for benefits under a Prescription Drug Expense Program sponsored by the Group.

    Prior Authorization: To obtain prior authorization for Total Parenteral Nutrition, Intravenous Antibiotics for Lyme Disease, or other injectable prescription drugs your Physician must provide appropriate records to Premier Blue prior to providing services and Premier Blue will authorize coverage if the Medical Necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if Medical Necessity is supported when the claim is adjudicated.

27. **Reconstructive Surgery**

    For purposes of this provision, reconstructive surgery means reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

    Benefits are available for:
    - **a.** Cosmetic or reconstructive repair of an Accidental Injury.
    - **b.** Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed to produce a symmetrical appearance.
    - **c.** Repair of congenital abnormalities and hereditary complications or conditions, limited to:

(1) Cleft lip or palate.

(2) Birthmarks on head or neck.

(3) Webbed fingers or toes.

(4) Supernumerary digits or toes.

d. Reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

SECTION Q. EXCLUSIONS

This Premier Blue Certificate of Coverage does not provide services or benefits for any of the following, regardless of who provides, prescribes, recommends or performs them:

1. Any service not authorized by the Member's Primary Care Physician unless otherwise noted in this Form.

2. Services for injuries or diseases related to the Member's job to the extent the Member is covered or is required to be covered by a worker's compensation law. If the Member enters into a settlement giving up his/her right to recover past or future medical benefits under a worker's compensation law, Premier Blue will not pay past or future medical benefits that are the subject of or related to that settlement.

In addition, if the Member is covered by a worker's compensation program which limits benefits if other than specified providers of health services are used, and the Member receives services from a provider not specified by the program, Premier Blue will not pay balances of charges from such non-specified providers after the Member's benefits under the program are exhausted.

3. The cost of services covered under Federal, state or local laws, regulations or programs. Examples are Medicare, and care for military service connected disabilities for which the Member is legally entitled to services and for which facilities are reasonably available to this Member. This exclusion does not apply to Medicaid.

This exclusion applies even if an enrolled Member fails to qualify for Medicare benefits solely by reason of not having purchased Medicare coverage; in such case, the Member shall pay to Premier Blue the reasonable value of services provided under this Certificate of Coverage which otherwise would have been covered under Medicare.

With respect to Medicare, the foregoing exclusion shall not apply if the Member is otherwise eligible for Medicare but has elected Coverage under this Certificate of Coverage as primary pursuant to the provisions of law.

This exclusion applies whether or not you choose to waive your rights to these services.

4. Benefits for any service that Federal or state laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).

This exclusion applies whether or not you choose to waive your rights to these services.

5. The cost of Covered Health Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense payment provision (by whatever terminology used - including such benefits mandated by law) of any automobile insurance policy. If you enter into a settlement giving up your right to recover past or future medical benefits provided in connection with the accidental bodily injury Premier Blue will not pay past or future medical benefits that are the subject of or related to that settlement.

6. Any drug, device or medical treatment or procedure and related services that are Experimental or Investigational as defined in Section A. DEFINITIONS.

7. Services for care or treatment of a mental health condition except as specifically stated herein.

8. Convalescent Care, Custodial/Maintenance Care, or Rest Cures.

9. Drugs and prescribed medications incidental to Outpatient care and insulin.

10. Eyeglasses and contact lenses servicing of visual corrective devices, or consultations related to such services; orthoptic training and visual training; refractive procedures including: radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature.

11. Private duty nursing except when Medically Necessary prescribed by the designated Primary Care Physician.

12. Services provided directly for or relative to cosmetic surgery or reconstructive surgery unless stated otherwise in the Covered Health Services section.

For purposes of this provision, the terms "cosmetic" and "reconstructive" have these definitions:

Cosmetic procedures and related services are performed to reshape structures of the body in order to alter the individual's appearance.

Reconstructive and related services are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

13. Blood, payment to donors of blood or charges for storage of the Member's own blood.

14. Procedures, services and supplies provided directly for or relative to sex transformations.

15. Services provided directly for or relative to the voluntary reversal of sterilization procedures unless required to correct complications resulting from the sterilization procedure. (Services provided directly for or relative to the sterilization itself are covered.)

16. Transportation other than covered Ambulance Services or those services listed as covered in connection with Human Organ and Human Tissue Transplant Services.

17. Personal or comfort items (such as television, radio, telephone, guest meals, admission kits and materials used in occupational therapy) and private rooms, unless Medically Necessary during Inpatient hospitalization.

18. Long-term physical therapy, occupational therapy, speech therapy, psychotherapy, and Rehabilitation Services.

19. Any dental services provided directly for or relative to the care, filling, removal or replacement of teeth or

previous restorations, except as otherwise specified in this Certificate of Coverage. Extraction of impacted wisdom teeth, including any hospital or medical expenses associated therewith.

20. Services provided in connection with the following dental conditions:

All services/conditions provided directly for or relative to the treatment of malocclusion or malposition of the teeth or jaws; dysfunction of the temporomandibular joints (TMJ) or orthognathic procedures.

Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

21. Non-medical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including prolonged rehabilitation services in a specialized Inpatient or residential facility.

22. Services provided directly for or relative to any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screening are mobile vans and school testing programs.

23. Charges for completion of insurance claim forms.

24. All charges provided directly for or relative to autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older. Hospital admission for the primary purpose of performing acupuncture, and acupuncture services provided to Inpatients and Outpatients.

25. In vitro fertilization, in vivo fertilization, or any other medically-aided insemination procedure or infertility drugs except for those benefits for artificial insemination as set forth in the Covered Health Services section.

26. Services by an Immediate Relative or Member of the Subscriber's Household. "Immediate Relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of the Subscriber's Household" means anyone who lives in the same household and who was claimed as a tax deduction for the year during which the service was provided.

27. Services or supplies provided in connection with obesity, including:

Surgical procedures and associated care provided directly for or relative to treatment of obesity, such as intestinal or stomach bypass surgery, stomach stapling, wiring of the jaw, balloon insertions and similar procedures.

Any service or supply provided directly for or relative to the medical management of obesity, including but not limited to surgery, office visits, laboratory services, prescription drugs, weight reduction programs and nutrients, except for the initial nutritional evaluation or initial counseling provided by a Contracting Provider when diet is part of the medical management of a documented disease, including morbid obesity.

Prescription drugs utilized primarily for the treatment of obesity. This exclusion applies even if the drug is prescribed for purposes other than the treatment of obesity.

28. All services provided directly for or relative to transplant procedures except those specifically set out as benefits.

29. Care and treatment of the feet unless such services are Medically Necessary, as determined by the Member's Primary Care Physician. Routine foot care, such as the removal of corns, callouses or the trimming of nails is excluded.

30. Enrollment fees for or services provided by a health, athletic, weight loss or similar club.

31. Purchase or rental of supplies for common household use, such as, but not limited to: exercise equipment; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses or waterbeds.

32. Purchase or rental of escalators or elevators; saunas or swimming pools.

33. Referral services for smoking cessation programs, pain management programs, and childbirth education classes.

34. Any types of services, supplies (including consumable and disposable supplies) unless stated otherwise in the Covered Health Services section or treatment not specifically provided herein.

35. Prescription drugs utilized primarily for stimulation of hair growth or other cosmetic purposes. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.

36. Automatic external defibrillators.

37. Travel expenses, mileage, time spent traveling, telephone calls -charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

38. Charges for autopsies.

39. Services that are not Medically Necessary, as defined in this Certificate of Coverage.

40. Care for health conditions which are required by state or local law to be treated in a public facility.

41. Court ordered treatment or hospitalization, unless otherwise covered hereunder.

42. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Certificate of Coverage.

43. Artificial aids including, corrective orthopedic shoes; arch supports; elastic stockings; garter belts; corsets; hearing aids, or the fitting thereof; dentures and wigs.

44. External and internal prosthetic medical appliances, which are Experimental or Investigational in nature.

45. Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.

46. Costs of biologicals that are immunizations or medications for the purpose to protect against occupational hazards and risks.

47. Cosmetics, dietary supplements, nutritional formula, and health and beauty aids.

48. Compound medications which are injected or completely used up at the time and place of service and which do not contain an active ingredient with a valid NDC number or which are used for other than an FDA approved indication.

49. Any food item including breast milk, formulas and other nutritional products.

50. Services provided directly for or relative to an injury sustained during the commission of an illegal act.

51. Services, supplies or prescription drugs provided directly for or relative to the maintenance of addiction.

52. Abortions except in those situations specified set forth in the Covered Services section of this Certificate of Coverage.

53. Educational benefits except for those pertaining to diabetic education unless otherwise stated in the Covered Services section.

54. Services for disorders specified in the diagnostic and statistical manual of mental disorders which are not attributable to a mental disorder that are a focus of attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Certificate of Coverage, it is not limited to those benefits listed for Nervous or Mental Conditions.

55. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any eligible provider.

56. Human growth hormone therapy or other drugs used to treat growth failure.

57. Diagnostic tests and evaluations that are performed solely for the purpose of issues at dispute in the context of legal proceedings such as an issue of custody, visitation, severance of parental rights, or damages in any kind of personal injury action.

58. Genetic Molecular Testing except when there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

59. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

60. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Member failing to complete the initial treatment plan.

61. Chemotherapeutic agent(s) inserted into a periodontal pocket.

62. Communication devices designed and used for enhancing or enabling communication except for an electrolarynx.